NO LONGER ALONE IN A CROWD: HOW A MODEL PROGRAM CAN BE UTILIZED TO ADDRESS THE NEEDS OF GRIEVING PSYCHIATRIC SURVIVORS ON LONG ISLAND

By

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ABSTRACT

NO LONGER ALONE IN A CROWD: HOW A MODEL PROGRAM CAN BE UTILIZED TO ADDRESS THE NEEDS OF GRIEVING PSYCHIATRIC SURVIVORS ON LONG ISLAND

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As an associate minister at *Jesus Saves Back to Life Ministry* located in the Bronx, which works with Hands Across Long Island (HALI), I have observed a lack of adequate support available for grieving psychiatric survivors who are experiencing difficulty transitioning toward healing. While the HALI organization serves a Long Island community of 130-150 survivors, there are survivors in both Long Island and the Bronx who have not been reached. If this need is not addressed, they may experience traumatic mourning. This demonstration project will design a program model that will assist psychiatric survivors experiencing grief, while creating a healing confidential to be duplicated in the Bronx.

This demonstration project has brought to the forefront the lack of adequate support available for grieving Psychiatric Survivors who are experiencing difficulty transitioning toward healing. If this need is not addressed, they may experience traumatic mourning. Before the psychiatric survivors' pain can be addressed, it is important to recognize them as being an integral part of our community. Although we have certainly been conscious of those who suffer with mental illness, since it has been recorded as far back as biblical times, we tend to shun and ignore them. The goal was to make the world at large aware of the unjustness psychiatric survivors are experiencing.

The church's lack of support to this particular community and unwillingness to move forward to accept them as viable entities to be nurtured and respected congregants was apparent. I was astounded at the limited knowledge the elders of the church had concerning those with emotional disorders. This glaring omission of the church must be seen in the light of the strides in the secular community to no longer marginalize this group of people. Yet, during the course of this project, there has been great interest shown in all generations I spoke with to avail themselves of the current knowledge

needed to embrace our psychiatric survivors with more than lip service, within and outside the walls of the church. This demonstration project has designed a program model that will assist psychiatric survivors experiencing grief, while creating a healing and confidential atmosphere.

This work is dedicated on behalf of those who made me aware how profound grief-loss can effect one, when it touches your inner circle as an adult. They were the catalyst in my inevitable quest for respite of the mind and soul when the world as I knew it was spinning out of control.

To Pamela Taylor - Every time I look at my daughter and see her actions, hear her speech, you are with me.

To Deon Taylor - Losing you was like losing my own son which you were in a sense.

To Sharndell Taylor - You were my first baby; you are always in my heart.

To Eric Pugh - My heart tugs, whenever your son looks at me and say's to his friends, "My aunt looks just like my father."

To Sharon Jackson - You began my spiral with untold grief, God blessed me with a best friend, kindred spirit and first cousin in one person.



Count on Me

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In my quest to acknowledge all who have been instrumental in supporting me throughout this toilsome, but exciting process, my wish is to eliminate no one.

I give all the honor and praise to my Lord and Savior for allowing me to reach this pinnacle of my education.

Posthumously, I thank my mother Ruby, who instilled a thirst for academia in me at an early age. I also thank my father George, who continues to have an inspiration for knowledge, which has spurred my commitment to education over the years. Heartfelt gratitude goes out to : My husband Franklin, you have always taken pride in my achievements of higher education, spiritually and academically. My children, Da'Mel, Kha'mi, Kimberly, Son/Nephew-Da'Marr (You always bring the laughter) who have always lauded my achievements, I appreciate your constant support and understanding. To my niece Mikyla, who always offered a helping hand, thank you. To my niece MiCole, your love for education mirrors my own. Eric Jr. and Kia I'm proud to be your aunt. Teneisha, every aunt should have a niece like you, couldn't have made it without your assistance. To my Godson Sam, I'm proud of you, continue to stay attuned to the Lord. To my grandson Davien, thank you, so much, for playing quietly while I finished my work

My sister-cousins, Stephanie, Constance, Nedra, Gail, Robin, Vivian (Sabrina) I couldn't possibly have processed so much heartache and tragedy if you all had not consistently stood with me throughout those 21 years. Love to all my nieces, nephews, cousins and grandnephews. If I left anyone out, charge it to my head, not heart.

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Table of Content

Introduction The Background of this Project 1

Chapter 1 The Setting 7

Chapter 2 Analysis of the Challenge Statement 11

Chapter 3: Research Questions 16

Chapter 4 Plan of Implementation and Evaluation 48

Chapter 5 Ministerial Competencies 96

Chapter 6 Reflections 103

Appendix Two: **DSM-5 LIST OF MENTAL DISORDERS** 153

Appendix Three: PROJECT FLYER 155

Appendix Four: CHURCH ASSESSMENT 156

Appendix Five ABOUT HANDS ACROSS LONG ISLAND (HALI) 157

Appendix Six HANDS ACROSS LONG ISLAND MISSION AND VISION STATEMENTS 158

Appendix Seven HANDS ACROSS LONG ISLAND PROGRAMS 159

Appendix Eight QUIZ ON MENTAL ILLNESS 160

Appendix Nine SERVICE POEM 161

Appendix Ten CERTIFICATE OF COMPLETION 162

Appendix Eleven HALI CELEBRATION OF LIFE 163

Appendix Twelve COUNT ON ME 165

INTRODUCTION
THE BACKGROUND OF THIS PROJECT

I looked down as we processed out of the church. We were part of a processional every Sunday, walking out to the strains of "Count on Me" by Whitney Houston and Cee-Cee Winans in the background. Yet, something was wrong with the music selection. I was supposed to be hearing "Because He Lives." I thought, "Wait, that can't be right. What was wrong with our minister of music? Where was my robe? And why was I walking ahead of Pastor?"

I saw six police officers marching ahead of me carrying what I realized was my sister's beautiful lavender (her favorite color) casket. She had finally lost her twenty-one year battle with renal failure. God had given her a pardon numerous times over the years when it was thought she couldn't make it. I cried out to Him, when her children (I thought) were too young; God said yes. I cried for her youngest son to have his mom at his college graduation; God said yes. I petitioned for her to see her baby become a New York City Police Officer like his brother; God said yes. I asked Him to let my sister survive the death of her son killed in Afghanistan, because her son had lost his last sibling, He heard me. For the last five years or more she had been sharing that her body was tired. But selfishly, I did not, would not hear her words because I was not ready to let go. You see for all of those years, people believed that I was her strength and support. The truth was I could not navigate without her; though she was either in a hospital bed at times or her own bed at home, as long as I could talk to her and touch her, all was well in my world. God gave me more time than I deserved to prepare myself. The grace and

mercy I was given during one of the most challenging times in my life, I could never repay. I will never forget what He has done for me. As we entered her final resting place, Miss-In–charge-of-the-family, I don't cry in public, felt limbless and had to be carried back to the limousine.

As children we always had that special person played with, share our secrets with and even stop speaking to at various points in life. If we were blessed that person resided in the same home and shared the same parentage; they are our siblings. Now when the sibling is older you will suffer at their hands: they picked on you, tell untrue stories that would get you in trouble with your parents. In addition, they would steal your clothes and wear them, read your diaries and share the contents. They would do horrible things to you and threaten you with bodily harm if you would tell on them. Unbelievably, your parents would give them permission to terrorize you with the words "Listen to your brother/sister or I will get you when I come back." As for your sibling, they would ascend the throne and become the ruler with the words" Take care of your brothers/sisters and don't let them ruin my house." Thus begins your life as a peasant, under the reign of King 'Horrible' or Queen 'Cruella'.

However, the other side of this is you have a best friend for life. In my case, my best friend was with me from birth. They protect you take, love you unconditionally, come immediately when they someone picks on you even if the person is twice their size. Amazingly your sibling will run interference with your parents for you and forge notes to your teacher from your parents when you are on your last warning from mom. She is more excited about being an aunt than you are about becoming a mother. She treats your children like her own. Sometimes, as in my case, your daughter grows up to look just like

her. You co-parent your children to view each other more like siblings than cousins. I realized we had been successful, when we had a passing in our intimate family and we asked our set of children individually "what type of flowers would you like to send?" My nephew and daughter looked at me incredulously and said, "We never separate, just one flower from us, the kids." My mom would have been so proud, she had instilled in me the day my niece was born that she (my niece) had two mothers, and I would always be responsible for my sister's children as she would be one day for mine. This is a very common assumption in my family and still in practice today.

My sister and I shared a bedroom, which was pretty common for siblings of the same gender during those years. The memories we shared in that bedroom such as talking out the window late at night to our friends who lived above or below our apartment. We had our first foray into smoking cigarettes and spraying "Glade Air Freshener" to cover it up the smell of smoke in our bedroom. We experimented with hairstyles and make-up and talked long hours on the phone and covered for each when we missed our curfew. We grew into best friends over the years.

Our mom passed away when I was in my late teens and my sister automatically stepped to fill her role. She never complained just assumed what she thought was her role in the family as being the oldest. We had two younger siblings. She never relinquished the bossiness exhibited over us and felt entitled our unending love and loyalty. After we all married and had families, my sister continued to be protective and was the glue that held the family together. All family events and holiday dinners were spearheaded and generally held at her home, until she became ill and I took over that duty.

My sister was diagnosed with renal failure yet never relinquished her role as the head of the family, even though by that time, I was pretty much assuming her role, while answering, (as usual) to her. Our father was very much alive and present however my sister like my mom was the one who everyone came to with problems. My sister had three children, two boys and girl who were very attached to her. I became very protective of my niece and nephews and they were assured, I would be there for their family.

That brave women suffered the loss of her two eldest children; her daughter to lupus and her son is considered a hero, lost his life, while fighting for his country in Afghanistan. For twenty-one years, my life was filled with hospitals, doctors, home health aides, therapists and dialysis, which were the services she required. Throughout this stressful, terrifying ordeal, I was fine as long as I heard the words, "we're trying a new technique," "we are performing surgery," "this new medication or procedure will help' anything except there's "nothing we can do." Her illness made our bond deeper. When you sit in the emergency room for twelve hours with a person or see hospital staff administer emergency dialysis in the middle of the night with, no one on the site except the medical staff and yourself and your faith, it is a life altering experience. I recall one morning, I was home when the doctor called and said she was failing. Her two choices were surgery, which she would never withstand or not administer any aggressive treatment and keep her comfortable until the end, which would surely come rapidly.

I raced to the hospital and found they (her doctors) were in conference to discuss her options, which all agreed were nil. During this time her cardiologist Dr. Levy stepped outside and spoke with me. He said, "Her only chance is the surgery, and if you believe in God, pray. I told him that was all I had been holding onto for the past fifteen years. Her

surgeon had no faith as he told me to prepare for the worst, as it was inevitable. My response was “God will have the final say.” The surgery was performed the next morning. We were there at 6:00 am. They had a prayer revival in her room the night before. Some of my relatives who were present were not necessarily church members. However, if love could pull her through, their love would have done it. I felt the power of the Holy Spirit as the petitions went forth. The reverend was truly anointed. My family members turned to me in shock and said, “I felt that.” It was my confirmation the Holy Spirit was present. I went home filled with peace and confident all would go well. The surgery lasted twelve hours. The surgeon came out afterwards looking glum saying the next twelve hours would be crucial, that was at approximately 7:00pm. The next morning, I rushed to the hospital as I approached the surgeon who I dubbed “Doubting Thomas” walked towards me with smile on his face saying, “come take a look at my work’ my response, “Let’s look at God’s work.” Needless to say she survived the surgery.

She was my greatest (and I hers) fan at my graduation from seminary with my masters, as well as wore the biggest smile when I became a minister. I cheered just as loudly for her, when in spite all the familial responsibilities she had been burdened with my sister received her Bachelor’s in Child Education, the first one of my mother’s children to do so. She set an example of pursuing higher formal education, which has trickled down to the next generation on multiple levels.

At the passing of my sister, I was drawn into an abyss of grief. I had weathered my brother, niece, and nephew’s (my sisters children were like my own) and comforted and returned my family to a sense of normalcy. However my sister’s passing took an

unexpected toll I had never experience before. Even though it irritated me to no end, how I wished she was by side as she had always been to share good and bad times, cook my favorite dishes, boss me around and tell me how to orchestrate my life. Though I tried, it was difficult bouncing back from this tragedy. I kept a brave face for our children, so I thought. Until I heard whispers such as, "don't put on that movie," "don't show that to mommy, it makes her go in the bathroom and cry." My daughter, who strongly resembles my sister, came home one day with a haircut that made her look like my sister's twin. Upon looking at my face, she immediately restyled her hair and has never attempted that or any similar style again.

As these incidents were occurring, I realized I needed to seek grief counseling. In March, 2013, to my surprise, there was grief counseling available the Bronx. Even Calvary Hospital came up null and void. There was grief counseling available, but none fit my specific need of sibling grief counseling. I eventually found counseling in the private sector. However, the emotions I experienced at the lack of grief counseling available remained with me. No one realized how deeply siblings too experience untold devastation upon losing one another.

When I decided to embark on a project, of course sibling grief counseling came to mind. However, I was pleased to find out that Calvary Hospital had implemented a sibling support group, one and a half years later. During this time, I realized HALI had a need for a loss/grief support group, although the community was totally different from the one I was familiar, I felt God's hand leading me in their direction. Thus began the project that follows.

CHAPTER 1
THE SETTING

As a transplant minister from the borough of the Bronx to Long Island, the opportunity was presented for me to work at *Hands across Long Island* (HALI), grass-roots, multi-service organization formed in 1988. It is the first mental health clinic both managed and operated by and for psychiatric survivors in the United States. Today, HALI is the largest and most successfully peer run multi-service mental health organization in New York State, helping over 35,000 consumers each year. HALI helps survivors/consumers empower themselves, by focusing on what people ***'can do'*** as opposed to what they cannot do. When survivors are meeting their responsibilities and taking pride in making personal choices, they are escaping the stigma, isolation and shame surrounding mental illness. This process of empowerment is in essence helping them lead fulfilled lives. As their website states, "HALI works with the expectation that people CAN and DO RECOVER, work, have meaningful relationships, become contributing members of their communities and lead lives worth living. HALI believes that people receiving services are not patients, but **PEOPLE WITH POTENTIAL**."[1]

Hands Across Long Island has two sites. There is one located in Jamaica, New York and one located in Central Islip. The Central Islip site is the one to which I am affiliated. This particular site consists of one long building with two separate entrances.

[1] "About Hali," Hands Across Long Island, http://www.hali88.org/about-us/ (accessed September 19, 2016).

Both entrances are located in the front portion of the structure. The exterior is painted white with blue trimming. The street is a mix of both commercial and residential occupancies: The Victoria Bakery, Iglesias De Dios Camino Salvation (church), Allstate Carburetor, Tri-State Tire and Wheel Alignment along with private homes.

From the exterior, HALI looks similar to any other storefront, which is an assumption that is quickly abolished once you step inside the front door. Immediately, you are welcomed with the buzz of activity, smiling faces, and the warm connections between and among the people. It is literally physically palpable; it warms your soul and puts a smile in your heart. Inspiring messages of hope are seen everywhere, like Bob Marley's "You just can't live in that negative way…Make way for the positive day."[2]

Even with the warm and welcoming atmosphere, there is a strict security policy that requires all visitors entering the HALI premise to login. The receptionist, who inspects your identification and to whom you state your reason for visiting HALI, greets everyone. If you have an appointment, you must be seated until the person you are visiting is ready to receive you. The reception area is brightly decorated denoting holidays and seasons. Religious holidays are also noted in the hallways and glass cases that line the corridor. The building has more length than width. There are approximately thirty rooms, which house the staff, medical, maintenance offices and classrooms. The lighting tends to be mild, except in the Great Room, which is serves as a community room, dining room and a conference room.

HALI was established from the experiences of a community member and her family who felt painful isolation and stigma following a mental health hospitalization. It

[2] "Bob Marley, "Positive Vibration," Lyrics," METROLYRICS, http://www.metrolyrics.com/positive-vibration-lyrics-bob-marley.html (accessed September 25, 2016).

has been under the leadership of Ellen M. Hellion since 1993. As Chief Executive Officer, Ms. Hellion has lead this organization in such a way that it has steadily evolved from initially weekday drop-in centers to Personalized Recovery Oriented Services (PROS), supported housing, advocacy, a resource center which consists of a lending library and a computer lab and consultation services.

Currently HALI provides Supported Housing to over 150 individuals in Nassau and Suffolk Counties. In addition to rental subsidies, HALI case managers provide regular visits with the tenants to assist them in a multitude of activities from daily living skills, to employment and the acquisition of benefits. The housing is available through Single Point of Access (SPA) referrals for individuals with mental illness are independent in maintaining (Transformation, Recovery and Resilience).

In 2009, HALI blazed new trails by building a home with private two-room spaces for each resident with shared common interests promoting a sense of independence and well-being. At HALI, each applicant is interviewed and has the opportunity to meet with potential housemates to ensure there is a match in personalities prior to placement in the home. This project was a true community endeavor. Support from the State Senate, Suffolk County, towns and neighbors made this possible. The Central Islip home, targets homeless individuals who have additional physical issues. HALI assists with obtaining home health care services, if eligible.

There has been a spotlight recently on the church's seemingly detached stance on aligning itself with the mental illness community. This has resulted in a great deal of dialogue concerning what clergy can do to offer solace, care and our unwavering support to psychiatric survivors. As a member of the clergy, I recognize that we cannot rectify the

wrongs of our past; but we can work toward improving our future relationship with the mental illness community. Jesus Saves Back to Life Ministry is noted for their commitment to the community, which began with focusing on youth and young adults. It has been observed that some of the youth and young adults that have been a part of the ministry have suffered with mental illness or have family members who suffer from the same malaise.

The location of the Jesus Saves ministry is in the South Bronx where vestiges of mental illness have shattered many lives. Having been a former resident of the Bronx, I was able to witness the lack of mental stability impede neighbors' and acquaintances' opportunity to receive the services needed to assist them. Hopefully, the skills I acquire will not only assist the clients of HALI but will be helpful to the community of Jesus Saves as well.

Working in HALI has made me very much aware of the lack of spirituality available for the participants. I am presently implementing a "Grief/Loss Program," which for me as a minister, is based upon spirituality. Ironically, that is probably going to be my greatest challenge, trying to help others find God without actually using the terminology denoting "Him" as such. Having always come from a Bible based faith community, spirituality and God are simultaneous as far as I am concerned. I'm sure it will take a bit of innovation and creativity on my part to achieve a successful healing, peer-oriented grief /loss support group at HALI.

CHAPTER 2
ANALYSIS OF THE CHALLENGE STATEMENT

Challenge Statement

> As an associate minister at *Jesus Saves Back to Life Ministry* located in the Bronx, which works with Hands Across Long Island (HALI), I have observed a lack of adequate support available for grieving psychiatric survivors who are experiencing difficulty transitioning toward healing. While the HALI organization serves a Long Island community of 130-150 survivors, there are survivors in both Long Island and the Bronx who have not been reached. If this need is not addressed, they may experience traumatic mourning. This demonstration project will design a program model that will assist psychiatric survivors experiencing grief, while creating a healing confidential to be duplicated in the Bronx.

Grief/loss has touched the psychiatric survivors in the much same manners as the surrounding communities. As a result of the escalating crime rate, loss of employment, shattering marriages, loss of companionship (including the loss of pets) and loss of dignity, many in the community are feeling isolated and alone. As an associate minister working with lower income families, I have intimate knowledge of the devastating effects such tragedies wreak upon families, which include psychiatric survivors. The HALI organization expressed their concern of the lack of support available to their community and the need for intervention. During this time there was the loss of a staff member, which had a traumatic effect on the community at large. Shortly after, there were a number of deaths within the community from illness, as well as, one murder. The

emotional turmoil of the participants was very heart wrenching, as they tried to seek comfort in the one place they all considered a second home.

The organization was very sympathetic to the emotions of the community. Social workers psychiatrists and medical doctors well as various staff members spent time trying to assist through their crisis. The work schedules of the staff did not allot the time frame needed to assist in transition from grief/loss to healing nor, would they be able to work-one-on one to facilitate reconciling and be effective in their daily duties at HALI.

Although the needs to for grief/ loss support has certainly been thrust to the forefront since for the last 20 years, the psychiatric survivors seemed to have been forgotten in the attempts to offer reconciliation/curative measures for the mourning community. Loss is a part of life, and grief is a natural part of life the healing process. The reasons for grief are many, such as the loss of a loved one, the loss of health, or letting go of a long held dream. Dealing with a significant loss can be one of the most difficult times in a person's life. There are different types of loss, feelings of loss are very personal and only you know what is significant to you. People commonly associate loss with strong feelings of grief. These can include:

- Lose of a close friend
- Death of a partner
- Death of a classmate or colleague
- Serious illness of a loved one
- Relationship breakup

- Death of a family member

Subtle or less obvious losses can also cause strong feelings of grief, even though around you may not know the extent of your feelings. Some examples include:

- Leaving home
- Illness/loss of health
- Death of a pet
- Change of a job
- Move to a new home
- Graduation from school
- Loss of a physical ability
- Loss of financial security

Jesus Saves Back to Life (ministry/congregation) of which I'm a part of, is located in the South Bronx, which houses many impoverished families. The people who reside there have limited access to the healthcare (mental) service which could be conducive to their well-being, due to finances, lack of knowledge or limited assimilating abilities. The mission of Jesus Saves is to guide people to God, with a special focus on youth and young adult ministries. Our main focus is on the spiritual well being of the people we serve. We hope to teach God's Word replacing the sin of violence with love and respect. We believe that with God's strength, families will be able to communicate openly and honestly to solve problems. We plan to work with community and

government leaders to address the needs and concerns of our communities. We hope to bridge the gap in communication between the generations. We plan to put into place educational programming, which will aid our community in taking education off of the back burner and bring literacy concerns to the forefront. We would like to in time establish a scholarship fund to help deal with the astronomical cost of higher education. We plan to develop creative ministry efforts such as drama, rap and liturgical dance. We believe that by giving our youth and young adult's variety we may find something that holds their interest and keeps them out of trouble. We want to build leaders for tomorrow, because without leadership we falter.

Although the churches initial focal point was the youth and young adults in the area, adults ultimately gained inclusion. Jesus Saves now has expanded its focus to include all in need. However, the psychiatric sector in the grieving process seem so be left out of all the regenerating and developing being implemented in those communities today. Presently the church/ as well as political advocators in the South Bronx seems to be absent or clueless to the plight of psychiatric survivors need for grief/loss support recalibration in their own communities. There have been great strides made by those suffering with mental illness with the proper grieving loss support in various locations.

Although as a minister connected to a ministry in the south Bronx, while working at HALI in Central Islip, my reach is limited. Yet, my goal is to transform an entire community simply by helping one person at a time to receive the support they need and be able to assist those going through their mourning period with peer support during

healing. Hopefully, this will evolve into peers acquiring the skills to facilitate a grief/loss support group.

Peer support leadership is part of the independent living model, which allows expression of people's desire to be in control of their own lives. When you are a part of a peer support group (especially grief/loss) you realize how important it is for a person with a mental disability to have the experience of meeting and talking with another person with a disability. It opens up the recognition of the uniqueness of their experience.[3]

If I can facilitate in creating a peer/support group within the HALI community ad then duplicate the model with the Jesus Saves ministry community, hopefully this will elicit the necessity to take a second look at a vital part of our communities that is being overlooked along with spurring an agent of change within the church to support and protect our most vulnerable.

I have been given the support of the HALI community. They have graciously assigned a meeting area that is confidential, comfortable and quiet for our meeting space. HALI assists in any way they can to assist with my project. My prayer is that the model program created for HALI will be just as successful when duplicated for Jesus Saves Ministry and will encourage healing from grief/loss.

My Site Team has expressed enthusiasm for the project and is determined to make a difference in the lives of our most vulnerable during their transition from grief/loss to

[3] "Supporting Others Who Are Grieving," CMHC UT Counseling and Mental Health Center Division of Student Affairs Grief and Loss, https://cmhc.utexas.edu/griefloss.html#supporting (accessed September 26, 2016).

healing. The one challenge in the foreseeable future is our consistent use of the Christian titles for our Creator, which is restricted within the HALI organization.Chapter 3

CHAPTER 3:
RESEARCH QUESTIONS

Research Question 1: (Biblical)

Has there been a misconstruing of biblical themes, scriptures or comprehensions that have caused psychiatric survivors to feel neglected and detached from spiritual grief/loss healing? Which Biblical stories speak to Psychiatric Survivors in the twenty-first century? What can current biblical scholarship offer as a resolution to grieving psychiatric survivors seeking healing?

The Word and Mental Illness

Jesus Restores a Demon-Possessed Man

> They went across the lake to the region of the Gerasenes. [2] When Jesus got out of the boat, a man with an impure spirit came from the tombs to meet him. [3] This man lived in the tombs, and no one could bind him anymore, not even with a chain. [4] For he had often been chained hand and foot, but he tore the chains apart and broke the irons on his feet. No one was strong enough to subdue him. [5] Night and day among the tombs and in the hills he would cry out and cut himself with stones. [6] When he saw Jesus from a distance, he ran and fell on his knees in front of him. [7] He shouted at the top of his voice, "What do you want with me, Jesus, Son of the Most High God? In God's name don't torture me!" [8] For Jesus had said to him, "Come out of this man, you impure spirit!" [9] Then Jesus asked him, "What is your name? "My name is Legion," he replied, "for we are many." [10] And he begged Jesus again and again not to send them out of the area. [11] A large herd of pigs was feeding on the nearby hillside. [12] The demons begged Jesus, "Send us among the pigs; allow us to go into them." [13] He gave them permission, and the impure spirits came out and went into the pigs. The herd, about two thousand in number, rushed down the steep bank into the lake and were drowned. [14] Those tending the pigs ran off and reported this in the town and countryside, and the people went out to see what had happened. [15] When they came to Jesus, they saw the man who had been possessed by the legion of demons, sitting there, dressed and in his right mind; and they were afraid. [16] Those who had seen it told the people what had happened to the demon-possessed man—and told about the pigs as well. [17] Then the people began to plead with Jesus to leave their region. [18] As Jesus was getting into the boat, the man who had been demon-possessed begged to go with him. [19] Jesus did not let him, but said, "Go home to your own people and tell them how much the Lord has done for you, and how he has had mercy on you." [20] So the man went away and began to tell in the Decapolis how much Jesus had done for him. And all the people were amazed. (Mark 5:1-20 NIV)

The above passage of scripture conveys how many clergy and their congregants interpret mental illness today. They focus on Jesus removing the demons from Legion and returning him to a state of normalcy. The story of Legion is always touted as pastors/clergy's supporting stance on mental illness and the only means of curing it. It is interesting to note that people who have vulnerabilities such as mental illness look at this particular scripture quite differently. Guth suggests, "the possibility of viewing mental illness as a social location with the potential for offering valuable insights into biblical texts.[4] Guth then posits that it is possible for people with mental illness will see this scriptural text as a text that offered significant points of identification and resistance.[5]

[4] Christine Guth, "An Insider's Look at the Gerasene Disciple (Mark 5 Biblical Interpretation from the Social Location of Mental Illness: 1-20)," *Journal of Religion, Disability and Health* 11, no. 4 (2007): 61-70.

[5] Ibid.

Love and forgiveness two words Christians constantly utter and must be carefully expended when applied to Survivors. We must seek to be continuously uplifting while remaining optimistic. Redemption and resolution are sought by all Christians, however the affection of our Savior cannot be connected through grace and mercy for iniquities (delusions, uncommitted sins) not established. To be operative in our quest for the healing of healing of mental illness, we must utilize the tools that have been made available. We must never overlook the significance of medical, psychiatric, emotional and spiritual care, psychotherapy or professional pastoral psychotherapy are in in salvaging and preserving optimum health for the mentally ill. We must enlist the aid of our church families and render a call of action to increase the care P'S, and their loved ones, which is a mandated for Christians as our brother's keepers.

While researching this project it became evident that my perception of mental illness was quite inadequate, being considered (we are all diagnosable to a certain extent, whether we admit so or not) an outsider of their community. That being the case of so many of us, we can only see from our own location, which can tend to be limited. Trying to process any scripture from the location of a person with mental illness is similar to trying to see with 20/20 clarity when your vision has been diagnosed as 50/40. The feat is impossible.

According to scripture after the demons had been exorcised, Legion was healed. Similar to a person with mental illness being given medication and mainstreamed and all is considered well, they retreat into their now comfortable (for us) normal world and we can feel that our need to serve has been realized. My plight today being after the illness

has been identified and arrested through medication and therapy are they welcomed back into the community?

> What do you say? - After you and your friends finish with supper- we get in your boat and row back to the other side of the lake. If you let me join your join gang, I'll do anything you ask. I'll leave everything and follow you-not that I have anything to leave. No one around here is going to want me back in my family, even if the spirits are gone.[6]

I find there has not been a measurably favorable outlook on mental illness since the biblical era. Yes, we now more often than not refer to the condition as an unclean spirit, an alternative to demon.

However that is basically the extent to which many have moved in the millennium concerning our approach to mental illness today. As noted above Legions hesitancy to feel accepted into the community is well founded today. We have communities that will gather petitions, impede construction and form rallies protesting construction of residences for the mentally ill in their residential areas. Committees have been formed countless times by homeowners in the hopes of compelling the local politicians to honor their request. I also have been aware of countless times in urban areas the aforementioned housing has been in place and functioning for a year or more without the communities knowledge of its residents mental condition. The situation became a focal point upon the media touting it as a successful project, hoping to garner support for Psychiatric Survivors. Needless to say, once the community found out, it created a quagmire.

The stigma that is attached to one experiencing mental illness is very apparent today even after the proper protocol for curing/healing is applied. We consider ourselves more knowledgeable society than our descendants. Do you know that stigma is about disrespect and stigma is about using a negative label to describe a person living with

[6] Christine Guth, "Legion No More: Confessions of the Gerasene Disciple," *Journal of Religion, Disability and Health* 11, no. 4 (2007): 71-78.

mental illness? Do you know that people would rather tell an employer they committed a petty crime and were in jail than admit to having been in a psychiatric hospital?[7]

We, as a community are also at fault. Our lack of advocacy and use of such derogatory terms as, she/he must be "schizo," he could be a poster child for bipolar, or he/she's too OD for me when describing our friends in humor is totally inappropriate. These labels are part of medical diagnosis for those suffering with traumatic emotional disorder and should be treated as such. They certainly weren't created or classified as such for purposes of jesting.

The problem of defining insanity is particularly acute in connection of divorce. An insane wife cannot be divorced. Freehof is wrong in stating that the reason for this is because it amounts to divorce by force since the ban on a husband divorcing his wife without her consent did not obtain one in Talmudic times.[8]

While examining mental illness and the church, I was made aware of the Jewish community's perspective on mental health. The Talmud, they (Hagigah 3b) visit the cemetery in the wee hours of the morning rips their garments and spend the night. They believe divorce requires banishing the wife from the home, while citing Deuteronomy 24:1-4) which essentially says, a mentally ill women cannot be sent away, because she will always consider herself married and their marital home her residency. However they can conveniently, what I consider condone polygamy by releasing the ban against it, as long as they provide for the disturbed spouse. This allows the problem of the emotionally disturbed wife to be settled. Much to the satisfaction, I'm sure of Hebrew males.

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[7] Joe Padilla, "Overcoming the Mental Illness Disconnect in the Church," The Grace Alliance, April 12, 2015, http://mentalhealthgracealliance.org/christian-mental-health-and-mental-illness/the-spiritual-connection-of-mental-illness42015 (accessed November 5, 2016).

[8] Ibid.

However with the male sector divorcing him is not allowed, the feeling seems to be he is not cogent enough to understand the proceeding. Unbelievably they do allow a man suffering with mental illness to enter into matrimony during his cogent periods. The perception is that defining mental illness can become quite intricate, as a man could have possibly been deemed sane upon his entering into the marriage and become unstable within the course of the marriage rendering him an unlikely candidate for divorce. At a point such as this the wife is termed (Angunah) a woman not eligible for a divorce.

> It happened about five years ago, said the Jewish woman who was speaking anonymously at the other end of the telephone line. It was summer, and she was sitting at a Princeton Township swimming pool with her violent and difficult nine-year-old son, who had been struggling since it was summer, and she was sitting at a Princeton Township swimming pool with her violent and difficult nine-year-old son, who had been struggling since birth with bipolar disorder, a mental illness. "I was sitting at the pool, and I saw a mom wheel in a child who was seriously physically disabled and unable to take care of herself. All of a sudden, three or four of the other moms started to hover around her", the woman said, describing the scene of sympathy and support. "And I started to cry. My friends had all abandoned me. They didn't want to be around my bipolar child. What was flooding through me at that moment was the wish that people could understand that it's just as hard for a family with a child with emotional disabilities as for a family with a child with physical disabilities - even if you can't see it", she said.[9]

Another form of heightened awareness was the Jewish community, distaste of mental illness, which shows congruence with other faith communities. I assumed appearing such a devout and highly deemed believer of God and his dictates they would openly dispense love, compassion and understanding under all circumstances as other faith communities are deemed to. My assumption was incorrect, the above recount of a mother's experiencing a lack of compassion and understanding within her own community, based upon her son's unacceptable (according to this group) infirmity is appalling. Unfortunately such actions confirms that regardless of our ethnicity,

[9] Barbara V. Paper, "Mental Illness, a Jewish Concern?," JDC International Centre for Community Development, 2008, http://www.bjpa.org/Publications/details.cfm?PublicationID=3764 (accessed May 1, 2017).

demographics and affluence and so-called religious beliefs, parents with children that are mentally ill are faced with the similar treatment and thoughtfulness consistently. This should not be the norm; we must join forces to reverse this type of behavior.

As we look at Saul who became psychotic with paranoia and delusion, due to jealousy of David and rebellion toward God, we see a case of which appears to be schizophrenia. Then there is Nebuchadnezzar who was considered delusional after being directly stricken by God, which had more characteristic of dementia, then insanity. His healing by the Almighty seems to support the theory that only God can remove mental illness to those with limited knowledge in that area. David even pretended to be insane in order to preserve his life. (Sam. 21:21-15) He was well aware of the stigma attached to mental illness and how uncomfortable it made the people, royalty, peasants, Christians and gentiles alike into shunning them. Sometimes Christian concepts of sin and forgiveness are inappropriately used in many ways that heighten paranoia and clinical depression. Great care must be exercised in to those whose mental illness results in self-negation. The feelings of some with mental illness are reflected in the poem below:

The Hush of Mental Illness[10]

Hush! Say the families. We'd be embarrassed for others to know.
Hush! Say the siblings. We'd rather die than let anyone know.
Hush! Says the minister. Someone might feel uncomfortable, you know.
Hush! Says the deacons. We look after the physically ill, you know.
Hush! Say some church members. I don't want anyone to know about me or my relatives, you know.
Hush! Say some church members. I don't want anyone to know about me or my relatives, you know.
Hush! Say some government leaders. There's not enough money to go around, you know
Hush! Says society.
Cause we don't already want to know, you know.[11]

[10] June Zwier and Winnie Visser, "Let's Talk! Session Two Breaking the Silence," Let's Talk! Breaking the Silence around Mental Illness in Our Communities of Faith Study Guide, http://webcache.googleusercontent.com/search?q=cache:YWz62-0Fk2kJ:shalemnetwork.org/wp-content/uploads/2011/12/Lets-Talk_Study-Guide_final1.pdf+&cd=1&hl=en&ct=clnk&gl=us, quoted in Gunnar E. Christiansen, "The Hush of Mental Illness" (lecture, Integration Symposium, Anaheim, CA, February 15, 2012) (accessed November 20, 2016).

The repugnance and discomfort of mental illness by religious institutions has been continuous through the eras and to our dismay very much present currently. People who suffer from mental illness tend to agonize greatly from the humiliation as well as criticism and judgement of their communities. We must not discount the stigma many associate with mental illness. The world, based upon Webster's dictionary classifies stigma as a mark or imprint/stamp indicating embarrassment or non-validity. We can view stigma as an obstruction that systematically detaches those suffering with mental illness from society.

Gunnar Christiansen MD. Chairman of Faith Net/volunteer states, "It is time for us to convince the Faith Community that it should join in leading all of society in a march. It is time for us to shout and blow our horns. The wall of stigma of mental illness must come down. For most of us the wall is invisible. But those with one of these disorders can see it clearly."[12] The wall Christiansen refers to be transparent to those of us who don't (or so we say) suffer with a mental illness, we are unaware of. However, to those within the mental illness community there is a formidable wall that seems impossible to climb, rising from a bed of steel thorns making it impossible to walk upon/around. We are called to survey the survey the mountain, plan a maneuver to obliterate any elevations that may trigger feelings of degradation and prejudice to insure they no longer exist.

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[11] Ibid.

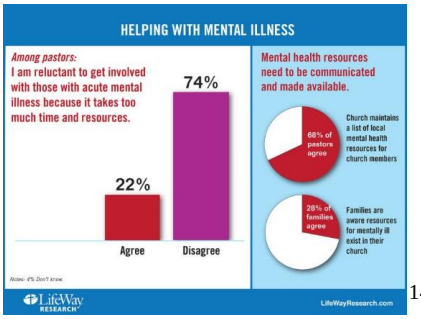
[12] Ibid.

One in four American suffers from some form of mental illness in any given year, according to the National Alliance on Mental Illness. Many look to their churches for spiritual guidance in times of distress. But they are unlikely to find that much help on Sunday mornings. My belief was confirmed through the study that most protestant preachers shy away from sermon topics approaching emotional disorders. Which is inclusive of the 50% who rarely broach the subject, 40% who seldom the subject a voice and 10% percent who totally ignore the topic.

There was a survey conducted of approximately 1,000 pastors all of which, senior was included in their in a quest to acquire knowledge of how their houses of worship.[13] According to research the intentions of pastors concerning their congregants that suffer with mental illness is favorable, however their accomplishments in that community are few. Researchers also conducted an in-depth interview 15 experts on spirituality and mental illness. The study showed pastors want to help those who experience mental illness. But those good intentions don't always lead to action. Church members especially the black community tends to turn to their pastors when confronted with situations confronting matters of the mentally ill affecting their family and rarely are their needs are not met. Apparently there is a feeling of being ill-prepared to counsel this populace, resulting in an averted opportunity to provide pastoral care, shelter and compassion to those desperately in need.

Below is a graph of what lifeway considers "crucial detaches":

[13]Ibid.



[14]

The muteness assumed by the church promotes the feelings of embarrassment of emotional disorders experienced by Psychiatric survivors. That silence can leave people feeling ashamed about mental illness. We tend to promote their feelings of invisibility and indistinctness. Even more appalling is the feelings of not being in aligned with the will of God. We openly discuss arthritis, cancer even aids from the pulpit, however mental illness is taboo, go figure. I learned that contrary to belief not only is ostracizing and being ignored difficult

Psychiatric Survivors feelings of feeling detached from spiritual healing from grief and loss stem from the conventional reception they receive from the church. Because of the initial reaction there is difficulty trusting and seeking compassion in times of grief/loss. Some of the challenges they are faced with are, the fear of stigmatization, which can be a gateway to isolation and jeopardizing one's thoughts, emotions and conduct. Being misunderstood, lack of council seems to be a constant characteristic of Psychiatric Survivors' interaction with the church. The worship style of many churches today may be an impediment to the attendance of the mentally ill. Today we incorporate thunderous music systems, vibrant. Energetic, lighting and preaching styles that can fluctuate from penetrating to pressuring. All of this is done within the presence of a large

[14] Ibid.

crowd that can become quite vocal depending upon their emotions. Understandably, most churchgoers in this setting embrace this type of motivating worship service, or they would not attend. However we must think of how it effects the community we are focusing on may become excessively accelerated, which could possibly lead to nervousness as well as symptoms not desirable. For many after attending worship services of this caliber, they are left with feelings of not being suitable for church followed by remorse and a need to be more active in the vineyard to elicit a healing of their conditions.

I have never heard many stories of having panic attacks in the church parking lot or just stepping into the lobby. Others triggered by the sermon get up and leave. In fact, one individual was told if he hard time with the sermon to call and we would have a simple bible study. He ended up calling the next Sunday.[15]

Most clergy or laypeople have not entertained the idea that the service we embrace wholeheartedly may cause much anguish and despair for others. We tend to feel that those surrounding us share most experiences. This is a great fallacy that can do irreparable harm if not reassessed immediately. The need for questionnaires and ministries specifically for Psychiatric Survivors, which can aid in placing them in the most suitable environment for worship service, is adamant. When mental illness becomes an issue of divinity, it develops into humiliation. While trying to make mental illness a spiritual issue, we will always reinforce stigma, falsely create dogmatic and superficial "spiritual' answers which then everyone gets boxed into…or for some, they get cornered. The problem is that spiritual stigma reinforces a broken heart …broken hope. The person

[15] Padilla, "Overcoming the Mental Illness Disconnect in the Church," The Grace Alliance, April 12, 2015.

struggling with mental illness has a story and a journey on with God's lovingkindness, grace and mercy. Mental illness doesn't intimidate God. Thus, mental illness doesn't define them, God does. That's the spiritual. Moving forward the church needs to embrace education, training, and community support.[16]

As a child, I remember being made aware that children with emotional disabilities were different. They came to school on a different type of transportation (short bus) and had secluded classrooms. In parochial school, they were educated in a separate building on the grounds. Along with our awareness came the knowledge of stigmatization with the thought that mental illness was something to be ashamed. Those who were diagnosed were to be considered inferior and contaminated. Throughout my teenage years, the perception had not varied very much. I believe my understanding and insight came from my cousin giving birth to a child with emotional disabilities. One of my friends gave birth to a child with emotional disabilities as well. Their children's births were my epiphany.

I watched children who were related to me being shunned, laughed, and picked on, while being ostracized by other children. I was so grateful that my parents had made it clear from the onset my social interaction with never to ridicule others. We were admonished to be grateful for our blessings. 'There, but for the grace God, go I' was my mom's constant refrain, whenever she witnessed another's affliction or misfortune. My empathy reached new heights as these children were diagnosed and sought services that would help them reach their full potential, while living in a world that did not seem fully prepared to accept them. My girlfriend's daughter went on to become quite functional,

[16] Charlotte Donlon, "Here's What Happens When Churches Ignore Mental Illness," *Albuquerque Journal*, September 26, 2016, https://www.abqjournal.com/853323/heres-what-happens-when-churches-ignore-mental-illness.html (accessed May 1, 2017).

partly due to her mom's early acceptance of her unique way of assessment. As a result, she has been employed in a company for over fifteen years. Her story so amazed many of the people she has encountered over the years that her story was featured in her city's daily newspaper. I believe her achievements were partially due to the sense of acceptance and love she has always encountered among her social and familial circle. This is quite a comparison to some of the children of the Psychiatric Survivors I encountered who had dual disorders and were prescribed medication. A few were even seeking admission to the programs similar to the ones their parents had attended.

'Fidgety Fairytales' is a play performed for children that provide glimpses into the world of mental illness. This play was created by National Alliance on Mental Illness (NAMI). The play has taken three fairytales and presented them in a manner that is conducive to an enchanting learning experience, allowing young children, an opportunity grasp a basic understanding of mental illness.[17] My only regret is it has not been offered in New York City to my knowledge, prayerfully in the near future

Children, who are blessed with gifts of being future thespians, delivered this performance. There was a tender comicality with a background of terrific melodies. This much-needed invention is considered to a delight for all ages; however, their targeted audiences are primary school age children, grades three through five. This play has heralded what we consider an untapped group of heroes in our communities, people who have mental illness, In 'Fidgety Fairytales', the heroes are people with mental disorders , the aspiration of the producers being to assist our neighbors in visualizing, how they would interact with those who suffer from emotional disturbances. This would have to be

[17] Joe Padilla, "Overcoming the Mental Illness Disconnect in the Church," The Grace Alliance, April 12, 2015.

done using techniques to diminish the concern and misjudgment we tend to experience in their presence. Considerations as well as reinforcements are great tools that can be used as well.

The National Alliance on Mental Illness is an organization committed to reducing the stigma of mental illness while promoting early recognition and achievement. This play has been recognized nationally to promote acceptance, dignity and social inclusion associated with mental health. The aim of their production is to provide accurate information about mental health disorders and to portray the strength and struggles of children with mental health disorders and help families, friends and communities respond with empathy, understanding and support. The Minnesota Association for Children's Health produces this play. The scripts have been reviewed by mental health professional, parents and youth with mental health disorders.[18]

Perhaps had this type of awareness been in place earlier they would not be such a high rate of stigmatism prevalent today. Many who have suffered and continue to do so would have benefited, as well as their families and even society. Many times what we embrace as children follows us into adulthood and eventually life.

Research Question 2: (Historical)

What has been the history of grief/loss for psychiatric survivors in the Central Islip area?

(Hands Across Long Island)? What has been the level of involvement of community leaders, advocates, and government involvement? What, if any, practices have been implemented to prevent this downward spiral of emotional trauma and how

[18] Ibid.

has it affected the community? How has this been addressed by the community from a spiritual prospective when the community restricts the verbal acknowledging of any deity?

The trauma many adults are experiencing today may have been minimized if there been the knowledge and empathy, society, as well as some clergy are currently displaying. During my discussion with the Judy Dubois, Chief Operating Officer of Hands Across Long Island, it was mentioned among other tidbits of history that there had always been a high ratio Psychiatric Survivors in Suffolk County. When I reviewed my notes that comment caught my attention. I became engrossed with exploring the accuracy and the cause of her remark. Also mentioned was the fact that was a result of the closings in Pilgrim State, Kings Park and Central Islip Psychiatric Centers.

During the 1900's, New York City had a severe spatial problem in its asylums. There were six mental hospitals in operation to necessitate the increasing need for psychiatric care, there were several approaches considered to resolve the issue. However the ultimate decision was made have the patients relocated to a farm in Long Island with a relaxing atmosphere to work in; the land was very inexpensive to purchase and plentiful on Long Island. Acquired were 1,000 acres of land in Brentwood Long Island the town adjacent to Central Islip where HALI is located. New York's Governor Alfred Smith had the support of the public and lobbied the legislature to arrogate funds for acquiring a 10,000-bed facility to house Psychiatric Survivors.[19]

They sought certain requirements for the Brentwood, Long Island region. Beside its vastness, the facility must be autonomous. They anticipated generating their own

[19] About OMH," New York State Office of Mental Health, https://www.omh.ny.gov/omhweb/about/ (accessed May 1, 2017).

water supply, which they achieved by creating a water tower. A power plant was also necessary for their vision, as well as sewage system, electrical system of light, heating plant, athletic fields, greenhouse and farm. They actually seemed to have created a town within a town, where no necessities to living a productive life were neglected. The town boasted of its independent post office, movie theatre, fire department and law enforcement unit. There was also an interment area because there was approximately one death per day. There was a laundry area, and entertainment section. The hospital itself consisted of buildings constructed specifically for pathology. There was a court and church. There was even housing built for the doctors and nurses employed at Pilgrim State. The facility was named after Dr. Charles W. Pilgrim, who was the Commissioner of Mental Health during the 1920's.[20]

Treatments at Pilgrim included many types of shock therapy: methods that were risky, but the only kind of relief available that science could offer at the time before Chlorpromazine (Thorazine) was developed in the 1950's. They include: Insulin shock therapy: The patient is injected with large doses of insulin, which causes convulsions and coma. Introduced at Pilgrim in 1936. Metrazol shock Therapy: Injections of Metrazol (or commercially known as cardiazol) quickly induces powerful seizures. Electric Shock Therapy: currents of electricity are passed through the brain to induce grand mal seizures, commonly used to treat schizophrenia and mood disorders.[21]

The aforementioned therapies were implemented in Pilgrim State in the 1940's, there was an inquiry conducted which examined patients who were compelled to endure

[20] "Pilgrim State Hospital History," Pilgrim State Hospital, http://opacity.us/site23_pilgrim_state_hospital.htm (accessed November 20, 2016).

[21] Ibid.

the horrific treatments. Lobotomies, pre-frontal lobotomies appeared to be the procedure choice for doctors administering care to the mentally incapacitated patients at Pilgrim State. Tom Jarriel of 20/20 did an intensive report on lobotomies in 1992, highlighting the serious impairments one could ensue from this "Treatment". Such residual effects were the plight of Beulah Jones following lobotomy treatment, her physical health sorely diminished. After the exposure of Ms. Jones case, Pilgrim and other state hospital bean to decline with advent of pharmaceutical alternatives to institutionalization.

My project allowed me the opportunity to become intimate with the mental health population; and the very idea that they could have possibly been denied the opportunity to lead functional lives had they been born decades earlier was distressing. Many Psychiatric Survivors have been mainstreamed into the workforce, as well as the world of academia and resulting in contributing solid citizens. All of the above would not have been possible if it had not been for God's mercy and grace toward the afflicted and the talents and abilities he blesses us with. His blessings allowed chemist, doctors and the appropriate agencies to ban together and create a medication that moved the mentally impaired to a state of functionality, without harsh impairing treatments of the past. Thereby allowing man, to be agents of change in their lives.

With the decline of Pilgrim, Kings Park and Central Islip Psychiatric Centers, the population was moved from their facilities and many became homeless. There were others who maintained their relationship with the hospital/centers for social services as well as medication maintenance. During these visits it was expressed to a social worker that they felt abandoned and had lost the sense of camaraderie they had while institutionalized. After hearing the same comment repetitiously, Barbra W., their social

worker, decided to take matters into her own hands and began a crusade to recreate that sense of belonging and establishing a safe haven for the Psychiatric Survivors and their peers with the help of the director, at that time, of Kings Park Mental Health services. Thus was the birth of Hands Across Long Island. Grants were written and the government lobbied for assistance. Eventually, permission was acquired to establish a home away from home for Psychiatric Survivors.

The property acquired was located at 159 Brightside Ave, where it remains today. The location has thirty-seven rooms. Initially HALI had a staff of eight; today the employ a staff of seventy. They have an enrollment 157, sixty percent of which are a part of their housing program. There are higher percent of male than female attendees. They're participants are either Black or Caucasian. There seem to be no apparent reason this limited ethnic grouping when questioned. The duties of the employees have certainly changed over the years. The C.O.O. informed me of her early year's chore of bathroom maintenance in addition to her office responsibilities, this chore was rotated among the staff. Today HALI staffs (4) maintenance workers who perform those duties. With establishment of Hands Across Long Island there were programs implemented, they offer twenty-two classes to their participants. They also facilitate There are variety of programs for the participants to join. The program has fulfilled its vision of becoming a home away from home to Psychiatric Survivors who felt abandoned by their prior programs.

As you walk into the Great-Room it resembles a family room. There is a section where snacks are readily available, a beverage area constantly being replenished with hot and cold offerings. A table filled with pizza, various dips, salsa, fruit, variety of chips and desserts are at ones fingertips. The meals are of the quality I would prepare in my own

kitchen. I would be hard pressed to believe anyone would need an additional meal at home, snacks maybe, food no. There are Styrofoam utensils at one's disposal for take home meal request. There are at least three entertainment rooms where movies and T.V. programs are watched, and music is played, while they lounge on sofa, loveseats and chairs. There is also an area for billiards, Ping-Pong and other table games. There is continuous socializing throughout the day.

They have become so successful that there is a second site in Jamaica, Queens. The sites are very similar with the exception of the Housing Support program, which serves over 150 survivors just in Central Islip. I asked Barbra W. of the challenges faced at one site opposed to the other. Her response was, "Transportation at Suffolk is much more difficult than Jamaica, at the urban site they use metro cards and are able to commute on their own. In the suburbs we have to obtain car service for their traveling, which includes obtaining voucher assistance and having a staff member on hand to navigate with the car services."[22] I also was told that the urban site was much more regimented; when a Psychiatric Survivors was in the building they were attending classes. Not the case in Central Islip the participants my come to the site and not attend a class or meeting all day. The atmosphere was one of being at home and in a relaxing state with no pressure to adhere to a strict schedule. However, for the most part, survivors attended more than one class daily.

Hands Across Long Island strives to excel and believes in the capacity of others to excel. People are the bedrock of the organization, and we invest in human potential-in ourselves, in community leaders with vision and passion, and in individuals and

[22] Judy Dubois, Chief Operating Officer, and Barbara W., Hands Across Long Island (HALI) interviewed by author, October 15, 2016.

communities dedicated to transform. Below, I have shared some of the programs and sessions offered at both sites.

Self- Help Groups: Believing that the best support comes from one who has walked the road. HALI facilitates over 30 groups throughout Suffolk County. Each group has their own identity and diagnosis. The group members support each other throughout the struggle of copping and living with mental illness. The group participation replaces the isolation and self-stigmatization with companionship, hope and the ability to help someone else. *Facilitator Training*: This is a seven-week training course for potential facilitators, provided skills and instruction in philosophy of self-help, building group cohesiveness, understanding group dynamics and facilitators. I learned long Island's first twelve-step program was initiated at HALI, which focused on the persons seeking recovery from the menaces controlling their lives. Drugs and alcohol dependency were their nemesis; compounded with a verdict of mental illness they were accelerating on a surefooted path to destruction. The program was aptly named *Double Trouble Group.* They also pride themselves on the creation of a program (In-Patient Advocacy), which found to be a much-needed service all persons hospitalized, particularly those with mental disorders. During my Grief Loss sessions .I met a young lady who had been hospitalized. At the time of her treatment and rehabilitation, her husband and family rejected her. She felt devastated, embarrassed and alone. My greatest challenge with her was sharing her shattered life. Because some the ladies were members of the aforementioned group (In-Patient-Advocacy) she experienced a small level of comfort. I constantly heard the words "we'll take care you." "I'll help you get on that program",

"Don't talk to that guy, he's no good, I will straighten him out later" "Everything's going to be fine". They're protectiveness and reassurance made me aware of the significance programs such as these have, especially in their community.

Since the close of hospitals, the increase in homelessness among people diagnosed with mental illness and the overload on the community based mental health system; many individuals are being arrested for non-violent offenses, such as loitering. Working with local precinct, HALI is contacted by the police to intervene, divert arrest, link the person to services to meet their needs and promote recovery. The project that focuses on this plight is the *Pre-Arrest Program*.[23]

I had been made aware of the sorrowful condition within our state and quite blatant in New York City, concerning the homeless population being housed at correction facilities, specifically Rikers Island. The then union leader of New York's Boldest, Norman Seabrook, shared at an Correction Officers graduation I attended in 2015 that over 50% of Rikers Island's inmates had mental disorders and committed nonviolent crimes that could, but didn't necessarily warrant arrest. Loitering and trespassing are their primary reasons for being jailed and for the homeless that can mean a warm bed and food for those, which otherwise might be deprived.

Although there are agencies and social workers who actively seek this community on foot if necessary; Psychiatric Survivors trust issues are so deeply imbedded most times, they cannot seem to process the opportunities being presented. One can imagine my joy, when I realized that HALI had decided to put lip service to their commitment of

[23] About HALI," Hands Across Long Island, http://www.hali88.org/about-us/ (accessed September 19, 2016).

helping all members of the psychiatric survivors, community by creating a program to prevent incarceration for the emotionally disturbed homeless.

There is a group named *Consumers with Conviction Project*, which is a statewide effort to bring self-help groups to inmates of state and local correction facilities. The goal is to link to recovery oriented communities prior to release, so they will have a 'safe' place to go work on their recovery, decreasing the chances of re-arrests. Currently HALI runs groups in Sing-Sing and Riverhead and will be starting groups in Mid-Hudson. Individuals run the groups with identical experiences as those in the group. The program is one I had no prior interaction with or knowledge of, it targets the Forensic mentally ill population. This program is not limited to Long Island; there is a statewide endeavor. Although, it was briefly mentioned, I had no concept of forensic, nor the gravity of its label especially pertaining to the mentally ill.

There was a man in my group who participated infrequently: however he was always kind, helpful and intermingled with the group. He was quite well spoken, well dressed and personable. When I learned of the improper infractions he had committed, while coming in contact with an innocent lady, surprised is a very mild terminology to describe my feelings. Needless to say, my senses were heightened and I became very observant. Brought to my attention also was a participant, who was convicted of one of the most horrific crimes a male can commit against a female, ***Rape***. He was the epitome of the adage: "You can't judge a book by its cover." This man, because of his conviction and release, was now engaged in the forensic program at HALI, using techniques he had be taught by his social workers to seek help when the urge to commit a crime came upon him. He had developed a system where would come into the center and get medication

and see his counselor until the feelings dissipated. I pray fervently that he will continue follow the techniques he has been taught to curb his inappropriate behavior. Prayerfully, all of these men will continue receiving help, which will hopefully deter their continued felonious behavior.

The programs not referenced, but available at HALI are as follows:

Transportation, Information and Referral service, Dances and Holiday Celebration,Food Coop Project, Supported Housing, Self Directed Rehabilitation, Bi-County Consumer Conference, DJ- Rock Program, Walk for Mental Health and community Kitchen, Zen Room, which is their latest program. They are constantly evolving and creating, programs that are contemporary as well as uplifting to their community. Their curriculums, inspire, educate and motivate the participants, while ensuring their creativity flow is not stifled. HALI's allegiance to the mental illness community is showcased via support, compassion, encouragement and tenacity, which earned them the title of the first grass roots, peer operated organization for mental illness in the country.

Research Question 3: (Social Economic)

How do the current social, political, economic trends of the millennium affect psychiatric survivors experiencing grief/trauma? Who are their representatives and advocates? What is a suitable social/economic paradigm for grief/loss in the psychiatric survivor community? Who should be on the forefront of designing the social/economic model appropriate for the survivors?

Liberals, or left-leaning civil libertarians, are more ambivalent proponents of expanded mental health services than we might otherwise expect, for fear of constructing an administrative apparatus or service delivery system that could undermine consumer

rights. Meanwhile, those on the mental health right, who worry that too many civil liberties mean disordered and dangerous individuals on the streets, are impatient with services restrictions, whether they originate with state budget-cutters or managed care companies.[24]

Today we live in a realm of division when it comes to mental illness, without delving into ones political affiliation, especially in the United States. There are those who feverishly advocate for expanded mental health service, as well as those hesitate, unsure questioning the effect it may have on their safety. Our senses have been heightened considerably, concerning our daily activities. Recently I have heard those who commute daily by public transportation voice concern of the influx of psychiatric survivors they see on the buses and more particularly the train. I believe the train is more stressful because of the intervals of non-exit that occur while moving between stations. Although they seem to be focused on the apparent struggles some riders may have yet are they giving any thought to those whose illness is non-detectable?

We have to be ever mindful of the person sitting next to us on the train or working at the desk across from us at our work. What we fail to realize is the man or the woman who is singing to himself or herself, is probably less of a threat than the preppy dressed individual sitting across from you who may on medication. They are engaged in a battle within their mind, telling them not to hit, kill or maim the person in front or next to them; or jump or push someone on the track. We cannot conceive this may be occurring, simply

[24] Lynn M. Sanders, Adam G. Hughes, and Nicole K. Pankiewicz, "Rights, Responsibilities and Ideology in the Politics of Mental Health" (annual meeting of the American Political Science Association, Seattle, WA, September 6, 2011), https://aghughesdotcom.files.wordpress.com/2012/03/sandershughespankiewicz_apsa_sept2011.pdf (accessed November 5, 2016).

because of our distorted views of what mental illness looks like. This can lead to a crescendo in your vulnerability to this community.

Therefore there is some fence straddling within the majority of the biosphere concerning the expansion of managerial provisions for health care for the mentally ill, citing jeopardy of their basic rights. The remaining percentages are struggling with the reality of the scenarios described above. My question to the world at large is, "You will advocate for them, but do you want them for your next door neighbor?" There is a man who is a participant at HALI, appears to be a classic case of agoraphobia (severe anxiety of being outside). However, in reality, he has an extreme case of paranoia. Upon leaving his home, he experiences an overwhelming urge to sit on the train tracks and kill himself. Presently, he is receiving counseling as well as medication therapy. His neighbors simply feel he has a fear of being in a situation he cannot control.

As we examine the effects on our neighborhoods, we must take into consideration, next door neighbors, the children who are in a learning environment with our children, church members, and new and old friends, who are unwilling to share their mental status with good reason.

For the most part, psychologically disordered citizens who have received a psychiatric diagnosis no longer live in mental hospitals. At previous points in American history, those mental health consumers who were most seriously ill were publicly invisible, hidden away on the back wards of the state institutions of legend. Now, many of the individuals who years ago would have resided in institutions instead live outside of them, sometimes on the streets of American cities. This shift in residence has produced a

substantial shift in the public imagination surrounding persons thought to suffer from mental illness.[25]

The above statement is aligned with the shocking occurrences at Pilgrim State, Creedmoor, Willow brook hospital and far too many more to name. The shunning, ostracizing and mortification the patients suffered in those institutions were the catalyst for advocating social justice for the mentally ill community. There has been unlimited strides advances made within this community, however the work has just begun, we still have street's filled with the homeless, people who need a warm place to reside and receive appropriate meals. We must eradicate correction facilities as means of taking the undesirable out of our vision, prison does not provide the medication or resources they need for healing, There have been recounts of those within/outside the emotionally disturbed sector who commit petty crimes, to be eligible for a warm meal and place to lay their head and feel they have no other alternatives. Let me quickly note there are those like Saul who feign mental illness to gain entrance to various hospitals, Bronx State, Pilgrim State, and Bellevue Hospital among others currently house the mentally ill for various periods of time.

Some scholarship suggests that deinstitutionalization depended quite directly on the structure of public provision for persons with psychiatric disorders and diagnoses. The introduction of Medicare and especially Medicaid, and changes in the eligibility of persons with mental illness for Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) housing and food stamps, may well have played a greater

[25] Ibid.

role in emptying out state institutions than either the introduction of meds or the critique of psychiatric power.[26]

There has frequent dialogue supporting the above statement in my presence, which would seem quite plausible because without the resources currently available the welfare of this community would be in peril. Existing outside of an institution, while maintaining a quality of life would be virtually impossible with no means of income, or proper health coverage. Unbeknownst to many including myself, were the stipulations in place to obstruct psychiatric survivors to optimum mental and physical health care. The managed care programs are heralded as the only means of providing the additional underpinning needed to reinforce the stability of the initial programs created in the 1980"s to keep Psychiatric Survivors mainstreamed. The goal to eliminate the homelessness and other unpleasant behaviors of the mentally ill had thus failed in part; although there was housing and resources for food and menial health coverage, there was a large portion of the population who still had barriers to service. Although their goal (Managed Care) was far more appealing than prior solutions, the jury was still out on their effectiveness. I myself recall seeing so many homeless/mentally persons lining streets, sleeping in hallways begging on metro transportation, and panhandling in the streets. My thoughts were always at the time "Why don't they get help, there are so many resources available? "Why would one choose to live like that?" My questions were endless, my knowledge so limited. Lack of comprehension can be almost criminal. I believed most of what I saw and heard through the media and the opinions (which I thought were facts) of others. I never realized the importance of protecting the welfare of

[26] Ibid.

our defenseless spiritual siblings. The program of managed care seemed to refute its purpose of providing long-term, institutional care for the population that had difficulty or could not be mainstreamed successfully.

In 1996 and again in 2008, Congress passed mental health parity laws, requiring large-group plans that cover mental health treatment to do so with benefits that are no less favorable than the benefits provided for medical/surgical care.[27] The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) incorporated coverage for addiction treatment as well as general mental health care.[28] But the mental health parity laws didn't *require* large-group plans to cover mental health and addiction treatment. They only required the plans to provide parity if such coverage was provided. And parity laws didn't apply to plans sold in the individual and small group markets.][29]

There were so many affected by the supposedly amendment to the health care laws in effect for the psychiatric survivors. They law actually created more of a hindrance than assistance. Large companies employ the majority of metropolitan workers, which is the basis of their family coverage. The implementation of the mental health parity and its stipulation of not providing coverage to small or individual sectors so many were left with conditions that jeopardize their family's health and well-being. How does a mother look in to her child's eyes day by knowing there is help available for their condition, however the government deems them not eligible to receive such care. The above

[27] "Mental Health Parity Act of 1996," Society For Human Resource Management, https://www.shrm.org/ResourcesAndTools/legal-and-compliance/employment-law/Pages/MentalHealthParityActof1996.aspx (accessed November 5, 2016).

[28] "The Mental Health Parity and Addiction Equity Act (Mhpaea)," CCIIO The Center for Consumer Information & Insurance Oversight, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html (accessed November 5, 2016).

[29] "Mental Health Parity Act of 1996," Society For Human Resource Management.

situation would be considered a case of "They won't let me have it" or they said, "We weren't eligible" so often heard in the inner cities and low-income areas. Many years later I realized, when the word' they' was being used, it was referring to the government. Drug addiction was causing violent crimes, constant robberies, families were dismantled, and the list of damage is exhaustive. The combination of mental illness and drug abuse wreaked havoc on families for many years.

In 2013, a person with a bipolar diagnosis was unable to obtain private individual health insurance in most states.[30] The same was true for people with schizophrenia and other psychotic disorders, anorexia, alcoholism, and a variety of other serious mental or behavioral illnesses. Even for people with relatively minor mental health diagnoses, health plans were allowed to increase premiums during the initial underwriting process.[31]

This left the mentally ill populace with literally no recourse to their most significant and common illnesses. The situation was impossible people were denied medical coverage if for applied on an individual coverage, which can be extremely expensive if one had the means of doing so, which in most cases was not an option. The devastation one must have experienced when they worked as diligently or had more stressful positions than their neighbors and had to accept the substandard health coverage mentally and physically. Their only option was to accept responsibility for an increase in premiums from the insurance companies, for a single mother with low-income having more than one child, it was frightening position to be placed in. Also the clause of not being accepted by insurance companies if you had a pre-existing diagnosis when

[30] "How Obamacare Improved Mental Health Coverage," healthinsurance.org, https://www.healthinsurance.org/blog/2016/02/16/how-obamacare-improved-mental-health-coverage/ (accessed November 5, 2016).

[31] "Mental Health Parity Act of 1996," Society For Human Resource Management.

applying, as well as not being covered when you were diagnosed limited your mobility to seek a more affordable insurance. For some your location determined whether acquiring coverage would be a clear path for you .In times like these we say, "Jesus keep me near the cross." As I was made well aware at HALI, in the early 2000's medical coverage was not always inclusive of service for emotional disorders. There was study conducted by Health Pocket in the early 2000's which revealed, slightly a little over half (54% percent) of the policies contracted to individuals in the U.S. covered substance abuse treatment, while the coverage of mental illness was only slightly higher a massive 61%, unbelievable.

When President Barack Obama released his 2017 federal budget proposal, it was evident the administration is still committed to improving access to health care and health coverage for Americans. One focus area within the budget was $500 million in funding to help Americans with serious mental illness get the care they need.[32] Although Obama Care's entire focus was not directed toward mental illness, it certainly became the victory many had sought, fought and advocated for over the years in the psychiatric survivor community. Yes there was much controversy, however the results in acquiring services desperately needed and unable to be obtained were the answer to many fervent prayers. Families who had suffered, cried, beg and pleaded to no avail; finally were presented with an opportunity to be served and treated like other members of their community. Parents receiving unemployment and the poor working class were now eligible for the essential plan, a component of New York State Affordable Act. When previously they had no insurance coverage at all. Many obstacles presented by the health insurance

[32] "How Obamacare Improved Mental Health Coverage."

companies were hurdled over regardless of the cause of their health impairment. Mental health was always a primary concern of the Affordable Care Act, because of the statistic which confirm what many today are finally realizing; one five American will and have experienced some type of mental health issues within their lifetime. Some will share the experience and others fearing the stigma, embarrassment and shunning that can ensue, will not.

Prescription drugs are also an essential health benefit under the ACA. According to Health Pocket's analysis, 18 percent of individual market health plans did not cover prescription drugs in 2013. Thanks to the ACA, all new individual and small-group plans cover prescriptions, including medications to treat behavioral health problems. Gross noted that there are still access problems stemming from the fact that carriers can restrict their formularies (covered drug lists), despite the fact that mental health drugs appear to work differently for different individuals.[33]

While speaking with a social worker Ms. Ramon, I discovered that many mental ill patients had discontinued care because of the multiple problems accessing the correct mediation. Some patients apparently had acute reactions to certain generic medication, compelling them to dispense with their prescriptions. This was due to the insurance company's policy to dispense substitutions, for prescriptions not affordable to poor, low-income families. With the addition of Obama Care the psychiatric community and many others were able to climb the scales (silver, bronze, gold) medication formularies had created and receive the proper medication. Particularly disarming was learning the plight of those with chronic illness whose medication was not attainable due to financial status.

[33] Ibid.

Obama Care/Affordable Care Act was the catalyst to assuming a life of appropriate healthcare, dignity and pride.

Agencies that care for the most vulnerable are dropping like flies, victims of a mentality that stigmatizes psychiatric illness and a shortsighted healthcare system more interested in managing costs than managing care. This year alone, the Federation Employment & Guidance Service (FEGS), a $250 million agency, closed after 80 years. Catholic Charities will close its outpatient mental health clinic in Freeport in May. Previous L.I. victims were South Shore Child Guidance, the Family and Children's Association, Peninsula Counseling Center and Pederson-Krag Center. The pattern is clear: for decades big government has cut funding to mental health services across the nation, and the cuts just keep on coming.[34]

I personally witnessed the ravages upon the mentally ill when managing costs, supersedes managing care. HALI recently was the victim of such attack. One of their initial, most successful programs was under the scrutiny of managed care. I learned of utmost importance to the healthcare system was billable hours, the coveted entity, which aligns with the biblical phrase "For the love of money is the root of all evil (1Timothy 6:10). Apparently the agencies are projected to receive financial assistance to provide service to the mentally ill; however if the time and interventions spent with Psychiatric Survivors are not considered billable. There is no monetary recovery, which leaves the agency at a deficit. This results in the work force reduction, which seriously impedes the efficiency of the agency. How difficult it is for the staff to ignore the calamities that are

[34] Ron Honberg et al., "State Mental Health Cuts: A National Crisis," National Alliance on Mental Illness, 2011, https://www.nami.org/getattachment/About-NAMI/Publications/Reports/NAMIStateBudgetCrisis2011.pdf (accessed May 1, 2017).

hovering over their doors because finances will not allow assistance. They are encouraged to embrace Medicaid patients, which are one of the highest insurance financiers, and discourage those with menial monetary recovery. They use dismissal of full-time and replace them with per-diem employee's to reduce their overhead. Sadly, the persecuted casualties are the participants of the program, which has been eliminated. The feeling they experience is one similar to home eviction its heart wrenching to watch their effort to comprehend the life as they know, has changed permanently and they must seek a new service resident. In some cases, they return to "just hang-out" and see "what's going on" hoping to see their friends. The situation is devastating to workers and employees, so much so that they have proclaimed next Wednesday as HALI day, I along with former participants, previous/located staff and retires will be celebrating the great work this agency continue to provide within the community. Healthcare management must be mindful, when the community is no longer the focal point of community healthcare, cultures become dismantled, ethnicities are dismantled and Healthcare quality is practically non-existent.

CHAPTER 4
PLAN OF IMPLEMENTATION AND EVALUATION

Initially, my plan was to create a loss/grief support group for siblings. However, that plan was quickly revolved into a support group hiatus for Psychiatric Survivors. Upon my realizing the necessity of a diverse grief/loss group at Hands Across Long Island, I spent time in prayer and meditation on exactly what resources seemed to be

lacking and/or not focused on when dealing with this group of people. I then curtailed my concentration on three goals, which I felt would be attainable.

My first goal was to bring awareness to the church as well as the HALI community of the lack of grief, loss and healing recovery groups, which would be available to the Psychiatric Survivors. My second goal was to formulate a team from within and outside the community that would assist in in accomplishing these goals in an organized and structured manner. Part of the structure would be to conduct statistical research on grief and loss within the community as a pivotal point to identify the need for a safe and confidential environment. My third and final goal was to assist the group in becoming peer facilitated while promoting healing in their community.

The church as well as the community needs to be unwrapped from its cocoon of listlessness concerning mental illness and the resulting behaviors. We have stigmatized those who are living in various stages of emotional disabilities, because of our ignorance, which includes that of pastors, ministerial staff and congregants. I understand their lack of willingness to get involved. Our communities are turning a blind eye and deaf ear to the isolation, hurt, pain, and rejection we emitting toward them by ignoring and/or dismissing their presence. This was a classic example of non-servitude, Colossians 3:12 says, “Put on then, as God’s chosen ones, holy and beloved, compassionate hearts, kindness, humility, meekness and patience.” When striving to be models of Christ, should we not attempt to relieve the burden of loss for those who have assimilation challenges, as well as limited resources available for grief/loss support in this particular community?

Upon meeting the program director, I was given a succinct knowledge of the population I would be serving. We decided meetings would be held on Wednesdays, 45-

60 minutes per meeting. We discussed my introduction to the population as well as my goals and expectations. February 17, 2016 was the chosen date for my preliminary interaction with participants at the monthly community meeting. The director made me aware that my timing was particularly beneficial as the participants had just suffered the loss of a beloved psychiatrist; who had recently retired, as well as, a social worker,5 who had relocated. Because of the relationship that had been formed and their dependency on the aforementioned staff, the participants had a harrowing sense of loss and grief. The implementation of my support group was anticipated to produce a sense of adjustment to these type of life situations, while garnering support from others experiencing similar circumstances

My first task (aligned with my goal) was to get information concerning the participants, thoughts on grief and loss. I needed information concerning their openness to sharing their experiences with grief and loss with a non-member of their community. This was task somewhat accomplished, during my first introduction. Although I had been warned the reference to any particular deity would not be acceptable, I prayed fervently the night before and the next morning for the correct verbiage to engage this audience and still evoke a spiritual overtone. The meeting was held in the Great Room (during the monthly gathering), which is multi-functional space for events, meetings as well as an expansive rec. area. Present were participants as well as the staff members who would be instrumental in determining their facility's need for my project.

The demographics of HALI are male, female adults, multi-ethnic. I must admit being nervous upon my first meeting concerning my reception, as well as, how engaged they would be. Having not having any knowledge of how this particular population

viewed loss/ grief and assistance toward healing. When I explained my intentions to assist them in achieving respite from their personal grief and loss encounters; the response was encouraging. A few of the participants began to open up and to share their bouts with grief and loss.

The director of programs seemed quite pleased and willing for my project to go forth. Although, the staff appeared receptive and hospitable, I walked away uncertain whether I would be returning. Within the next two days I received a call requesting my assistance in bringing healing to the participants in the aftermath of three deaths one murdered, one illness and one natural causes. The first gathering was more communal not as truncated as I anticipated. Everyone was eager to share their feelings and how the deaths affected their normal routines in HALI. I was learning this was a sort familial relationship existing within many of the participants. We tentatively discussed a memorial service, upon approval from the director and willingness of the other participants.

I learned the project was received well. The staff felt that my role as a minister would set a more reverent tone and encourage spirituality. Now I must say here once again, at the onset of my interview, I was adamantly told there was never to be any mention of a deity, as this was a secular organization. How I struggled with that dictate. God is the head of my life, He is the functioning portion of my being and everything for me begins and ends with Yahweh. You can imagine the difficulty I experienced initially, trying to remember to refer to Him as a Higher Power, or as tapping the Spirit within etc., when I was used to Jesus, Lord, Father, Savior, Jehovah just to mention a few titles pouring from my lips consistently. I learned I was to officiate the memorial service. I

might add, although my project was received well; I had not been given the official stamp of approval.

However, God covers us in all situations and His presence will never be denied when he is in the room. The service was wonderful indeed we had a lovely attendance staff, participants and family members; as the service progressed, I heard shout of "Jesus" "God" and "Father" filtering the room. My worries were in vain. As always He is in control. Participants were invited to make remarks and some offered poems. There was laughter, tears, poignant memories shared by all. For me the most memorable incident at the first (there were others) memorial I officiated at the facility was a gentleman who stood on line, waiting to make a remark and when his turn became apparent looked over at me and said "May I sing a song for my friend?" Of course I nodded yes; somewhat surprised because I had never seen him verbalize much during my time at HALI.

This gentleman suffers with Traumatic Brain Injury (TBI), a form of acquired brain injury, occurs when a sudden trauma causes damage to the brain.[78] TBI can result when the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue. Every TBI is different, and symptoms of a TBI can be mild, moderate, or severe, depending on the extent of the damage to the brain. A person with a mild TBI may remain conscious or may experience a loss of consciousness for a few seconds or minutes. Other symptoms of mild TBI include headache, confusion, lightheadedness, dizziness, blurred vision or tired eyes, ringing in the ears, bad taste in the mouth, fatigue or lethargy, a change in sleep patterns, behavioral or mood changes, and trouble with memory, concentration, attention, or thinking. A person with a moderate

[78] "What Is Traumatic Brain Injury?," TraumaticBrainInjury.com, http://www.traumaticbraininjury.com (accessed November 1, 2016).

or severe TBI may show these same symptoms, but may also have a headache that gets worse or does not go away, repeated vomiting or nausea, convulsions or seizures, an inability to awaken from sleep, dilation of one or both pupils of the eyes, slurred speech, weakness or numbness in the extremities, loss of coordination, and increased confusion, restlessness, or agitation.[79]

He shuffled forward to the front of the room where the photos of those who had made their transitions were located and with his cap tightly clutched in his hand bellowed out in perfect baritone harmony "Amazing Grace," which caused the entire audience with tears in their eyes to stand, and for those familiar with the song including myself to accompany him, although he certainly didn't need it, in paying homage to a dear friend. I would also like to add the audience, including the participants were mostly attired in black; our traditional color of mourning. There were bells rung along with an announcement of each departed loved ones name. Flowers were lovingly placed in a vase in their memory, as the audience filed past the photos of their departed friends. Moving forward at other services that were conducted at the facility; prayer cards were asked to be included in the service by family members. The staff at HALI was particularly pleased that family members started to attend the services. Initially I was told we can invite them but they probably would not come. God blessed our service to have family participation. This set the protocol for memorial services during my shift at HALI.

After the first memorial service, I was told my program was accepted and the next order of business was to have my fingerprints taken. I scheduled the task for the following weekend everything went according to plan my sister and decided to have

[79] Ibid.

lunch afterwards. The technician told me the results would be ready in two weeks, the same information I received at HALI. After the required time, I'd had no response from the facility. The Human Resource person asked that I wait a couple of days while she investigated. The results were disappointing; they indicated there was a problem.

I turned to my sister once again, having to travel a distance to have the procedure repeated. I enlisted the aid of my sister for the second time to drive me there; I didn't have a license. Again, I went through the same procedure and was told by the technician a finger injury might be the culprit. She offered to list some digits (fingers) on my hand as being not present to insure an acceptance, to which I adamantly refused. I don't believe in speaking into the universe that which is not true, to me that is the same as cursing one's self. I informed her I trusted in God and He would straighten out the situation.

Needless to say, again, I waited three weeks this time. The human resource person informed me that the computer indicated my prints had been taken for the second time, however there was no declared status. She informed apologetically that once again she would have to investigate the process to work in such a delicate atmosphere is quite intricate and strictly adhered to for the protection of the clients as well as staff. We are now in the spring (beginning of May) season. I knew exactly what was amiss the enemy was trying to attack my project. I received that as confirmation that indeed this was the section of the vineyard God was assigning me to. In instances like this I stand on Ephesians 6:11 (NIV) "Put on the whole armor of God, so that you can take your stand against the devils schemes". The follow-up process extended until the beginning of June

was I was informed that my prints had finally been accepted throughout the system. Hallelujah! God always makes a way.

I officially began my project June 15, 2016. As I stated initially, my support participants have been diagnosed as Axis -1, which is a DMS-5 clinical classification. The DMS-5 is a Diagnostic and statistical manual of mental disorders, Fifth Edition is the 2013 update to the American Psychiatric Association (APA) classification and diagnostic tool in the United States. The DSM serves as a universal authority for psychiatric diagnosis, treatment recommendations, as well as payment by healthcare providers, are often determined by DSM classifications.[80]

Our first encounter was a bit difficult for me; I had no idea if I would have participants would attend or not. As I entered the room in a secluded area, relief filtered through me to see some participants looking toward me. It was not as many as I would have liked. I had hoped to schedule individual intake interviews. Unfortunately, this was not possible. I had to digress and recalibrate the process of retrieving information from this particular population. I decided after interacting with them that an oral interview with note taking by myself would be the best method to pursue. I also realized the group, most of which had been formed many years ago, were quite comfortable discussing personal matters in the midst of each other. Often looking to each other for clarification of information being given. This was their chosen method of interview. Meanwhile the rest of the group was involved in the chosen activity for the session.

Initially I suggested that they would decide which topics concerning loss/grief they would weekly follow. This led to a myriad of subjects being suggested. I decided we

[80]See Appendix Two.

would honor the most pressing matter for each person on a rotating basis. We closed that first encounter with an inspirational quote not necessarily spiritual. I always had some type of exercise for the group to indulge in that helped in creating a relaxing atmosphere. One type of these exercises is to paint a corrugated mask to reflect your feelings that day. While discussing your mask reflection lead to the topic day's theme for discussion. I also learned the standard time frame for classes (in my case meetings) were forty five minute intervals. Upon the completing of our meeting spoke with the program director and discussed my concerns and the size of the class. She assured me that it normally takes a minute for groups to form. Although we had certainly put flyers weeks in advance she stated the best means of informing the community was word of mouth (approval) from their peers.[81] I left that day thanking God in advance for the increase. I acquired a physical timekeeper, Justine.

I went home seeking information on how to engage the population for long periods of time and how to curtail the use of prayer in closing a session. Also on my agenda was delving into emotional disabilities and its characteristics, on the level of a proletarian because of my unfamiliarity with the subject matter. There was a lot of time spent petitioning and in supplication to be effective and empowering in an area I was unskilled in. I enlisted the aid of my pastor, mentor, prayer partners and site team for encouragement and intercessory prayer.

God always has an impending blessing if you are faithful your prayer. My prayer was answered in the form of the social worker, as well as other staff members; who made

[81] See Appendix Three.

themselves available to me, upon realizing this was my first foray into their field. Which was much needed blessing. Thus began my mini-education into emotional disturbances.

My second meeting was a bit more relaxing. I was quite pleased and surprised to find my attendees had doubled number as the program director had predicted and everyone seemed eager to discuss their loss. I had noted the focal point seemed to be the loss of relationships, dignity, housing, children then an actual person as were my intentions. However God makes us aware of his flock needs. Though there was a need for grief/loss support in this community the lamenting of someone seemed secondary to grieving the trials in their lives.

John was the participant who set the theme for the session which was the loss of a parent, not death related. For John his father's absence and the lack of available information pertaining to him personal or otherwise was an area that brought him a great deal of hurt in his life thus far. The alleged deception and secrecy of his mom and older sister served to further heighten the pain. As John began to tell his story it unleashed an avalanche of memories from other participants describing fathers/ or father role-models who abandoned the family without any explanation recalled in their childhood memories. Some of the females recounted tales of abuse and unsavory behavior, poor choices of husbands and partners, depression and unfortunate life circumstances were attributed to their lack of father figures. Many were just unhappy about the lack of communication and information to search for the absent parent. When the session ended, after closing with an inspirational quote, which became customary, John came over to express his appreciation for the discussion day's subject matter. He felt a sense of relief and peace never achieved previously in one-on-one sessions discussing his father. Needless to say I was thankful

for my heavenly Father answer to my multipurpose prayer. The most important facet of the support group for me was participants finding peace and solace in grief loss areas that were prohibiting their healing. I felt encouraged that day.

During this time I noticed other participants were starting to link into our group. I was quite pleased, but also well aware that in order to successfully complete my project in a manner that would bring reconciliation to the group in their grieving and loss, closing would be mandatory at eight participants, which we did implement. The closing had the potential to be risky as this particular community sometimes had difficulty committing, as well as, making you aware they would not be attendance the following week, even if they had advance notification. I also found the social workers requesting I make an exception and add another person if they were going through a particularly difficult grievous situation. Although I was accommodating, it was a bit peeving to me; as I felt I was constantly retracing my steps of the intake process when a new person was included. I was to learn, after accepting the members, that their need was greater than my core group's. Many times, we have to be silent and wait before expressing our opinion. After all was I not there in the role of a servant. Amen.

Our third discussion which was selected by a participant I will call Barbara, was on rejection and the pain it caused, because of the differences others saw in psychiatric survivors. She shared how while working in a supermarket, a position many persons with ED (emotional disabilities) seem to be able to secure. The treatment her employer, especially the manner in which she was spoken to was so depreciating and dismissive. The constant barraging of her employer seemed to filter down to the other workers, making her uncomfortable and depressed. She ultimately left the position and now has

difficulty seeking employment fearing the situation will be repeated. The group agreed they have all encountered this type of behavior when their employment was mainstreamed. The group shared with Barbara different techniques they found helpful when placed in the same situation. Somehow this discussion lead to fear of large crowds which many of the group has been affected by. Some of the antidotes recommended were shopping in the early morning hours or just before closing when the crowds tend to be less traffic. Smaller stores, the avoidance of holiday crowds and sales-day, were also an options discussed. I learned that many of the group had more of a focus on discussing Loss that was not necessarily on a physical being. We closed that first encounter with an inspirational quote not necessarily spiritual.

A component of my goal for the support group was to create a skit (see appendix?) that would incorporate various humanistic feelings, participant experiences, as a result of grief and loss. This goal was recognized in the innovative skills of one of my site team members (Renee Cartwright-Burney) who blessed us with an awesome skit depicting the varied emotions one can experience as a psychiatric survivor. We had a review afterwards with the audience.

The characters in the skit names reflected their particular struggles:

Paintra (pronounced Pain tra) is nervous and sad; Maddie (pronounced Mad dee) is angry and tries to hold back feelings and unsuccessful; Fearicka (pronounce Fear reek a) Southern accent and is timid; Regect (pronounced Reg ject) is upbeat yet feeling rejected and has tears of a clown syndrome. The emotions focused on in the skit are familiar to those with an Axis-1 diagnosis. I must say I was so excited to present the idea of a skit to the group and prayed for their response to be receptive. I was blessed to

receive the response I prayed for and was surprised to have three volunteers immediately. The others took a little coaxing to agree, however at the end of our group meeting I had cast most of the parts. The male role was my most difficult to cast; the women were more willing to be in the public eye. There was a gentleman who said he would be willing to take the role if no one else came forward. Of course no other male would commit to that particular role; although they were perfectly willing to have non-speaking roles and be part of the crowd for which I was grateful. Everyone's presence in the skit help to create the ambiance I hoped to attain. The gentlemen, whom I will call Pete, was labeled a forensic. At the time, I was not sure of its usage in that community. However I learned forensic mental health defined more broadly is an area of specialisation that, in the criminal sphere, involves the assessment and treatment of those who are both mentally disordered and whose behaviour has led or could lead, to offending.[82] In the civil sphere forensic mental health has a more complex remit, not only being involved in the assessment and treatment of those who have potentially compensatable injuries but also providing advice to courts and tribunals on competency and capacity. Having said that the skit went quite well we had staff as well as Survivors in attendance. The feedback we received, which I wasn't sure we would get, assured me, we had indeed communicated with our audience. There was a review, which quite a few took part in and led to discussion of the hurt pain, and anxiety they had endured over the years as a result of their various conditions. Again, I praised God for allowing me to see an illumination on my path to reconciling the Survivors with their experiences of bereavement.

[82]Paul E. Mullen, "Forensic Mental Health," *BJPsych: The British Journal of Psychiatry* 176, no. 4 (April 2000): 307-11, http://bjp.rcpsych.org/content/176/4/307.full-text.pdf+html (accessed November 20, 2016).

After reviewing the skit and the feelings it evoked with our audience, we held our weekly group meeting and continued to discuss the emotions the skit had provoked in a more personal setting. Also, participants as well as group members were given the following self-care strategies:

1. Face your fears.
2. Express your feelings in a tangible or creative way (writing, poetry, songs, crying, talking).
3. Look after your physical health.
4. Do not let anyone tell you how to feel, don't tell yourself how to feel either.
5. Plan ahead for grief triggers.

Our fourth meeting's was themed by an exercise in which the group was given tabs with various words such as, understanding, love, peace, respect, compassion, laughter to name a few . Their task was pull tabs which could be duplicated, position them in two rows. The first row should depict, what they felt they gave to others and the second, what they felt themselves needed. This led to a gathering that was quite enlightening. One of the participants (she suffers with a dual diagnosis, schizophrenia-bipolar) who was quite eager to share explained how she felt a great sense of loss concerning familial love. She went on to recount, how although she was consistently invited to family gatherings, upon her arrival she felt ignored. When asked what circumstances led her to this conclusion, we were told no tried to engage in conversation. She also shared the interaction with her and family members was minimal if any. As a recourse she would sit on the floor and play with the dogs the entire time.

Something in my spirit convicted me as she spoke as, I too have a family member who suffers with an emotional disorder. As I recalled our family functions, I realized there had been a time when my engagement with my relative after the customary hug was

minimal, simply because I wasn't sure how to interact with them, which led me to suggest to her, that perhaps the lack of inclusion wasn't intentional, it may have stemmed from her family not being sure how to engage. I also pointed out there was definitely love, something she questioned, in the midst of their invitation because many are shunned not invited to such gatherings. A few members of the group echoed my point, as they shared they had been ostracized from their families because of their various diagnosis previously and some still were ostracized. She seemed to have been reassured that her family did indeed love her. I also reminded her, how she was blessed they not only included her in large family gatherings, but her father and stepmother invited her to dinner (a fact she had shared), at least bi-monthly. I had surmised that a great deal of her anger was geared toward her stepmother. When asked about that relationship she remarked that until his marriage to his present wife, she and her dad had share dinner dates alone and felt the stepmother's presence as intrusive. As we continued to discuss her feelings, we arrived at what I felt was the catalyst her animosity for her stepmother. They had married on her mother's death anniversary, which spoke volumes about her dislike for her dad's wife. I have known people supposedly without emotional disabilities who have severed relationship with a parent for that very reason. Sometimes we have to be a little more sensitive to others feelings, In the midst of our exuberance.

There was also a group member who shared at length for the first time during this meeting that she also, no longer communicated with her family other than one sister. When asked why this was the situation she shared that she felt used by her relatives. Apparently they only engaged with her for monetary purposes or when they felt she would be beneficial to their needs. As soon as she shared her reasons for no longer

engaging with her family, it appeared a floodgate had been opened. I learned from most members present they felt a loss of respect for their intellect occurred with their condition. I heard numerous stories of how once diagnosed family and so-called friends took advantage at every opportunity, feeling you were not capable of discerning duplicity and insincerity. The pain, betrayal and anguish they felt made it impossible to continue the relationship.

Unlike the perception those family members and many others have, an emotional disability doesn't necessarily come with an added diagnosis of easily deceived. They would have done well to remember that the helpless are covered by this plea, "Save me, O Lord, from lying lips and deceitful tongues (Psalm 120:2 NIV)**.**

The fifth meeting moved to a more intimate level of discussion, as one of the Ladies shared her need to leave her present home setting, which was with her family. She felt her independence was being impede by her mother in particular. Also mentioned was the loss of a child (abortion) which she still mourned and seemed to be relate to her mom in some way. She recently applied for a residency in housing complex and was presently awaiting placement in an apartment complex near her family home. Her need for independence and to remove herself from her present environment was a subject that was updated consistently throughout our meetings. When asked why her moving was so important she said "My mom does not want me to leave", however she stated emphatically 'I can't stay there anymore." This unleashed a torrent of stories concerning housing complications others in the group had or were experiencing. One male group member shared how traumatic the loss of his Section Eight Housing Voucher was, and the devastation that ensued following his eviction.

After gently probing, I realized the incident had occurred over eight years ago. His recount of the loss seemed as if it were quite recent, to him I'm sure it was. Upon further inquiry of participants living at home when they appeared to be as capable of others who were living independently. One answer I received was, there was a need in the family, for the benefits they provided, to supplement the households income. These benefits would be returned to sole ownership of the participant once they removed themselves from the household. I found the aforementioned interesting and sought confirmation from others in a position to validate the information given. I received validation and realized this was an actual situation in some households. Also discussed was the living arrangements of another member whose husband/significant other took control of her housing situation and forced her to become a victim in her own home. Subsequently she passed away and one of the group's first reaction was to advocate for his removal from the housing unit. Apparently the housing subsidy didn't include him as only she and her son were eligible. Their most significant area of resentment was his restricting her use of the living/family room. The closing inspiration of our meeting that day had more of a spiritual overtone. I began to realize the group was quite open to religion than I initially believed. Still, I continued to stay on the marginal edge (it definitely was the apex) of their request.

Amazingly when she passed, her family (faithful Catholics) along with the partner attended HALI's memorial. As officiant of the memorial service, I was actually able to observe him, during the service. None of his actions, bespoke of the speculated ill-treatment, he supposedly rendered to the deceased. However, upon observing the participants response to his presence, there appeared to be some tension. The reception

toward him by the participants was lukewarm. The family, however, was quite warmly embraced by participants and staff alike. Her sons remarks “He’s my father, he misses my mom too, they must have loved each other at one time, because I’m here “. Spoke volumes to the credibility of the rumors. Also the lack of interaction between the partner and family was quite noticeable. I also found it interesting that the dad asked to speak with me and requested that try to aid them in having his grandson (the decease’s son) enrolled in the program. His request was echoed by the young man himself, as I left the gathering. I was quite pleased at how the service turned out; the family all personally thanked me, they even videoed most of the service.

Prior to the service, they were also quite helpful in sharing information as well as poems and pictures to be used during the service. I truly felt God had used me to bring this family peace, solace and a sense of pride in her accomplishments attained at the facility. I say this based upon her dad’s tears, upon hearing various participants, listing her certifications received while attending the P.R.O.S. program. I feel our service was quite heartwarming to the family. The staff always expressed their appreciation.

Our seventh meeting was themed by a member who had been added to our group at the special request of a social worker. This young man’s first words to me were, “Hello, My name is Bill, I want you to help me plan my funeral”. I was a bit surprised to say the least, as he stood before me with a somber countenance. The group was quite gracious, as he discussed, the overwhelming desire to plan his funeral service. Bill (fictitious name) suffered with Persistent Depressive Disorder.[83] I questioned if he had a terminal illness or had recently received devastating news concerning his health. His

[83]See Appendix Two.

reply was negative to both inquiries as he asked my advice on whether invitations should be sent out for his service. He informed me his brother would be executing his wishes. I was a bit puzzled concerning his persistence in making his final plans a focal point of his apparently vibrant life. I decided to find out more about his life and not his present obsession. As he and I talked I learned he had a girlfriend who had not communicated with in over two months. He shared that his belief was, her daughters did not care for him. When questioned how he came to this assumption, his answer was they weren't allowing him to visit her in the rehabilitation facility. I then realized part of his morbid outlook on life seemed to stem from a lack of activity in his personal life. I asked did he speak to her and he said her daughters blocked his communication. Judging from the last date of contact they had, I felt it might be beneficial to attempt a reach out again. I further explained, during his girlfriend's initial phase of illness her daughters were probably so overwhelmed trying to secure appropriate medical care and services for their mom they may have appeared uncaring of his feelings. I found out later, that indeed his girlfriends' daughters were initially overwhelmed and were perfectly willing to have their relationship resumed.

Other members shared their experiences of feeling rejected in their personal relationships. One lady who I labeled the diva (to her delight) said she could not understand how her 55 year old boyfriend preferred going to school for a Master's degree opposed to spending time with her. She remarked "who goes to school at that age" which amused me to no end. She also did not believe he preferred writing/researching term papers in the summer months when they could be enjoying the beach. This foray into personal matters confirmed when it comes of matters of the heart we are all more alike

than different. The previous statement, reminds me of the scripture "So in Christ we, though many, form one body, and each member belong to all others" (Romans 12:5).

Another young lady shared that her boyfriend whom I had met and normally a very quiet person invited other friends to join them on their outings and then become very talkative to them not her. She was especially annoyed about his conversing with a young lady from the program. She felt a loss of his attentiveness across the board. Group members who knew him and myself suggested she have a talk with and share some of her feelings in increments. During this session another member discussed his difficulty in speaking to women, who he found appealing. Beyond hello he was lost, His mind would not cooperate with his feelings and the thoughts in his head. I could see that being problematic for him, as he suffers with schizophrenia.[84] He walked away grateful someone finally took him seriously concerning his inability to pursue a personal relationship. He thanked the group for their encouragement and assurance he was not alone in his difficulty. Bill decided he would try reaching out once more to his girlfriend's family. Ultimately he would discover in the near future indeed they wanted the relationship with their mother to continue and welcomed him to communicate and visit. They explained as I thought they were initially overwhelmed with condition and making unexpected decisions. Apologies were made and although he was smiling more, he continued to question me about a list of crematories.

During our eighth meeting a group member who was suffered Anorexia Nervosa, which was not difficult to believe, based on her appearance.[85] She was quite an eager

[84] Ibid.

[85] Ibid.

member from her first day and finally decided on that day to share her greatest loss and the circumstances surrounding it. Apparently had been married to a man who was obese, and for unknown circumstances, they were forced to live with his mother. She found her mother-in-law controlling and meddling which only aggravated her condition. Ultimately she was hospitalized due to her condition debilitating. Her husband took this opportunity to serve her with divorce papers bedside. She suffered a mental breakdown and this facility was part of her attempt to heal. Her demeanor was one of humbleness. I was quite touched by her circumstances and determination to move from the dorm-like residency she now resided in (first step in gaining independent housing) courtesy of HALI into independent housing. She was quiet and never said anything negative about her present living arrangements, however you could see she struggled living in a communal environment.

Our final meeting (8^{th}) was a celebration as well as group meeting. I decided to have a catered lunch brought in as well as have the room decorated and secured the assistance of the kitchen staff for serving purpose. My intentions were to allow the group to realize there were very valuable and important in their own right. As they walked into the room they were quite surprised, there were comments of "This is beautiful, is the staff having a celebration?" "We're scheduled in the wrong room". At each place setting were gift baskets (filled with goodies) and a card. I paid particular attention to having one basket filled with sugar-free delicacies for a group member who reminded during each session of his adverse reaction to sugar. His gratitude and surprise was worth the extra effort. The kitchen staff stood in the front of the buffet table with smiles saying "No this

is all for you." All eyes were focused on me, everyone expressed their gratitude consistently through the meeting.

We had two new members, who had unfortunately joined the group quite late (Although I said it had closed) One man had terminal liver cancer and felt he had lost most of his family support and was looking forward to the group being his support system throughout his illness. He expressed sorrow when he realized I would be ending this phase of the group that week. The second young man expressed the multiple family members he had lost and the grief he was feeling, he felt the group would benefit him immensely from what he had heard. He was annoyed no one had informed him of our presence earlier. The group agreed unanimously they had indeed benefited from the program. One member shared initially she was not a part of the group she just happened to be sitting in the area designated for our meeting and found it quite interesting and helpful. Because her first day of attendance was in the initial phase of the group, it went unnoticed by me. She signed the time sheet at our first meeting and remained a consistent presence throughout the project. She was quite talented in the arts and wrote a poem for one of the memorials, as well as, picked out songs, for all to participate in. She appears to have characteristics of Depressive Disorder.[86] She was one the few who constantly made aware if she would be late (sometimes they had doctor appointments at the facility) or unable to attend a session which was only once.

Unfortunately there were participants, not part of our group who expressed regret for not joining our sessions, they were of the mind that we only discussed death of a human. Once their friends explained we also focused on loss/grief in every capacity, they

[86] Ibid.

were eager to join, however the group was certainly closed, at that point. There were many expressions of regret, as well as statements of "They have money for everything, why not to keep you" and "Now who is supposed to help us get over losing you"? "I have this class marked on my permanent schedule."

I felt my first goal was completed for the majority portion. The community workshop was not possible because of my site team being located outside of New York, and as you are aware the project was done in Long Island. The other strategies were completed.

My second goal also completed without the planned physical presence of my site team. We did the assessment portion during our sessions. Although, because of time constraints we were not able to incorporate role reversal and the interviewing portions. These goals in which my Site Team to partake, were accomplished via telephone in-put from my team. They were quite instrumental in giving guidelines on keeping the group focused on the intended direction, as well as having general knowledge of the community being served. Their knowledge came from their roles as social worker, nurses, and having a very family member suffering with emotional disabilities.

Goal Three was never recognized as strategized, my site ream was never able to enter the facility on a consistent basis for several reasons; transportation, lack of ability to get fingerprinted (required by facility) alloted time span entirely too short. However, this goal was realized through the assistance of various staff members who provided me with the insight needed to:

(A) Assess the facility's need for supplying a safe confidential zone.

(B) Providing insight for targeting this population.

Goal Four was never implemented as there were those who had the potential to become peer group leaders: however they were uncomfortable in one case and felt there was not enough time to prepare in the other.

I must say in accomplishing most of my projected goals I related to the scripture "Therefore let us draw near with confidence to the throne of grace, so that we may receive mercy and find grace to help in time of need" **(**Hebrews 4:16). My team and I being in totally different locations, Long Island/Bronx, Jersey, created a situation that only God could have worked to our advantage.

CHAPTER 5
MINISTERIAL COMPETENCIES

There were three areas my site team chose as sections of needed improvement. The competencies chosen were Pastoral Self- Care, Counselor and Spiritual Leader.

Pastoral Self-Care

There were strategies chosen to help with my lack of self-care.

I made plans to go to Ebenezer's Women of God conference in May. It was truly a rewarding experience to be with women on one accord with God. The women came from various backgrounds, ethnicities and geographic locations. Our bond was the love we have for Christ. For a three-day weekend, Christ was the theme. I was introduced to women whose struggles were similar to mine. Many women had challenges I was aware of however, by the grace of God had not experienced. I thank God for Pastor Joann Brown and her vision and tenacity to realize these women in clergy as well as our lay

sisters needed to come together for replenishing. I did meet a lady who had been attending the conference for quite some time; she shared that every year in the month of May, she's riding on empty and makes it to the conference just in time to refuel. There were classes specifically created for women in ministry to share their personal struggles with others experiencing similar discrepancies in their lives. We learned that we are not alone in our challenges in marriage, juggling family's careers and our commitment to God.

Marriage and the difficulties we face having spouses whose spiritualty is not aligned with ours, was given a great deal of discussion. Another Topic that was focused upon was single women's plight to find a mate that would respect their present spiritual location life. The world renowned Dr. Jazz told her story of abuse and pain so eloquently that she had the room in an uproar. Many women who had not been able to admit the exploitation they had received from a person they trusted and loved came forth and purged themselves of the guilt, anger and hurt they felt as a result. The preachers for conference were some of the most celebrated women in the

African-American ecumenical body, which included Dr. Renita Weems, Pastor Elaine Flake, Pastor Susie Owens, Dr. Jasmin 'Jazz" Sculark, of course our facilitator Pastor Joann Brown \and too many others to name.

The anointing over the sanctuary was awe-inspiring, healings and transformation took place friendships were made and revived. Reconnections with old acquaintances and networking were done. Our itinerary was packed with workshops that fed your spiritual hunger and thirst. They did not forget to include the activity dear to a women's heart 'Retail Therapy'. There were various vendors with every product that

enhances the physical appearance of women. I personally purchase clothing, body scrubs made from scratch; also bought were multiple CD's of discussions and workshops I wasn't able to attend. Unfortunately, the time allocated only allowed us to attend 4 workshops a day. The evenings were always reserved for an unbelievable worship service. After the conference I felt totally refreshed and empowered me.

I also visited Florida, Miami for a month of rest and relaxation, and also to catch up with the ladies in my circle, (we have been friends from childhood) and family. While there I was introduced to an alternative diet for a healthier lifestyle. I visited the Atlantic Center for Healing Arts and met Dr. Carolyn Ware, she is the owner of the Healing Center. Dr. Caroline, as she is called is a Holistic Health Practitioner. She came highly recommended by family and friends. Her expertise is in alternative medicine with a background in oriental medicine. She is considered an herbalist, or acupuncturist. Her treatment methods also include nutritional counseling, homeopathic, vitamin therapy and much more. Dr. Caroline is a Diplomat of Oriental Medicine. Her education includes attending the Atlantic Institute of Oriental medicine and a Bachelor of Arts in Health Sciences as well as a Bachelor of Arts from the University of North Florida.

Because of her knowledge in alternative medicine and the high recommendations, I felt comfortable seeking care from her. After a consultation, I was given a nutritional plan to follow and herbal medicaments. She encouraged me contact to her if I had any questions or problems. I found her to be a person of integrity and her candor was refreshing. I realized through being under her care that my daily sugar intake far exceeded the recommend daily intake. Also a lot of my low energy and consistent itching came from an improper diet. Following her regime has helped tremendously in

revitalizing myself to pursue the goals I set for my ministry. As a result, I am more aware of what I ingest and monitor the effects what foods have an adverse effect on my well-being.

Counselor

I decided to join a support group on sibling grieving at Calvary Hospital in the Bronx. This would give me an opportunity to extract healing for myself. Ironically, I had sought assistance with my own personal grieving when I lost my sister two years before. I had been referred to Dr. Alejandro, who is the director of the Bereavement Program. Unfortunately, at that time, there were no services to assist in healing the trauma of grief. Dr. Alejandro was kind enough to counsel me during my most difficult time. I will always be grateful, as I had multiple deaths within a short period of time, all of which were some of my closest family members. I found the Sibling Support Group, which is a six-week course, facilitated by Raman Randhawa to be a very well organized and structured program. Her course served a dual purpose for me. I interacted and shared my experience with others whose struggles were similar to mine. I also gleaned guidelines from the group as a basic model for my grief/loss program with the Psychiatric Survivors.

Calvary also offered a certificate course, accredited by the New State Dept. of Health: Bureau of Funeral Directors. The Annual Bereavement Course is a ten-week course on bereavement and grief related issues, taught by various specialists from Calvary Hospital/Hospice. Upon completion a certificate is presented to the participants.

The course was designed for those in helping professions and not for bereaved family members.[87]

Our itinerary consisted of the classes below:

Mar. 7th - Making Decisions at the End of Life (6:00-7:00pm.)-Christopher Comfort M.D.

Delirium Depression Dying (7:00-8:00pm.)- Robert Brescia M.D.

March 14th-The Hospice Prospective 6:00-7:00pm) Hospice SW TBD

Fundamentals of Grief Counseling (7:00-8:00pm)

Walesca Marmoejos LMSW

March 21st Multicultural Aspects of Grief (6:00-8:00pm)-

Father Chox Olochi &Pastoral staff

March 28th An Overview of Normal Grief (6:00-7:00)-Sherry Schacter Ph.D.

Disenfranchised Grief: Intuitive vs. Instrumental Grievers (6:00-8:00)

Sherry Schacter Ph.D.

April 4th - Death of a Child (6:00-8:00) Sherry Schacter, Ph.D.

April 11th- Death of a Parent (6:00-7:00:00) Raman Randhawa LMHC-NCC

Death of a Sibling (7:00-8:00) Raman Randhawa LMHC-NCC

April 18th- Children and Death Walesca Marmolejos LSW (6:00-8:00)

April 25th- General Bereavement for Young Adults (7:00-8:00) Walesca MarmolejosLSW

Death of a Spouse/Partner (7:00-8:00) Raman Randhawa

[87] See Appendix Ten.

May. 22nd- Initiating Bereavement Support, Groups and Intervention (6:00-8:00) Walesca Marmolejos

May 9th- Grief and Trauma (6:00-7:00) Sherry Schacter Ph.D,

Compassion Fatigue Sherry Schacter Ph.D.

The course was invaluable to me, although I suffered many challenges including a leg injury; leaving me on crutches for three months. During this time I continued to attend classes, on crutches hopping along, knee propped up on a chair during lectures. I live on Long Island and had to commute to the Bronx site for classes. I am continually seeking courses to assist me in being well prepared for this new ministry.

Spiritual Leader

I took an all-girls trip to upstate, the husbands were left at home; it was agreed by all we needed uninterrupted respite. What I did not know was I would be dispensing spiritual leadership and guidance during our retreat. Some of the women were not necessarily practicing Christians. All had recently (within the last 6 months) experienced family loss and in some mode of grieving. Once I became aware of the direction we were moving toward, I realize this experience would help me in one of my (Spiritual Leadership) competency areas. Every day we had sessions of sharing and caring, which is something I have done in my church ministry, there were one-on-one interactions in which I basically listened and allowed the person to voice their concerns of how to move forward with the void they were feeling.

We began a prayer service, which still exist today. I have also unknowingly started a thread of morning devotional, which has grown greatly since it began. This texting morning inspiring ministry began as means of lifting one of my friends up with scripture, prayer and devotion. My friend felt so blessed by our morning interaction that

she felt comfortable enough to share with others. Some women asked that their spouses be included. These texts are now being shared throughout their various circles. I am just thankful God continually blesses and guides me to a word that uplifts them daily.

CHAPTER 6
REFLECTIONS

This project opened my eyes to the challenges my brothers and sisters face daily, who are suffering with mental illness in their quest to survive. I am grateful to God for re-directed my project. I now recognized that advocating for Psychiatric Survivors is a part of my call to ministry. Though I am empathetic and compassionate to the cause of Psychiatric Survivors, never have I truly seen them through the lenses I now wear. My research has led me to discover how problematic the lack of clergy support has been to members of this community. How have those who have been called to serve neglect those who already feel marginalized? We have to remember the Word of God states in Matthew 11:28-30 that He would give rest to all who are weary and heavy burdened. His yoke is easy and His burdens light. They are supposed to trust in Him with all of our hearts and not depend on our own understanding as it states in Proverbs 3:5. They are to seek His will in all that they do and He will show them what path to take. He is the God who will give rest to their souls. They must trust in His word and believe that His Word will be operative in the heart and souls of those with mental illnesses. We know that when they walk in the midst of trouble, we know you will revive them, stretch forth your hand and save them. You have left your gift of peace in them and we pray their hearts will not be afraid. We confess that even though they may be pressed on every side by troubles, they will not be crushed and broken. They may be perplexed, but will not give up and quit. They may be hunted down, but You will never abandon them. They may be

knocked down, but they will get up and keep going. Father, we profess that they will lie without fear and enjoy pleasant dreams. They will not be afraid of the threat of disaster or destruction. You are their security.

During my research of mental illness grief/loss, there was a thought that resonated in my mind and spirit. The church and the world at large have been aware of the challenges and stigma attached to mental illness and the abandonment felt by those suffering. So why does the problem still exist in the millennium? According to my research, people have armed themselves with tools needed to eradicate the stigma and avoidance. Then why then are we still grappling with it? Could the answer lie in the fact that we live in judgmental, perfection-seeking world, which is the ideal environment for this type of negativity to flourish? We see headlines that focus on rare sensationalism circumstances that lead to violence and death. The media also plays a prominent role in advancing our understanding of mental illness and substance disorders. They have an opportunity to report stories about those with mental illness in a manner that can increase awareness and reduce stigma around these conditions.

Although there should be no limitation on those who assist in remedying this malady, the church should lead the way. Our churches by tradition in times of need seek to provide peace and refuge in moments of distress. In the face of adversity we seek the church for solace; it has be known to give us a sense of calm in the storm. The church has always been the "family" many African-Americans turn to fill the role when their biological families fail them. They have sent children to college, buried members when finances weren't available. The church has paid bills, purchased groceries and clothed

their neighbors. Why have we shirked our obligations when it comes to assisting our brethren suffering from mental illness?

What I find quite disheartening is that when those who are brave enough to share their struggle with emotional disorders with their pastors/clergy they are ignored, dismissed and made to feel they have committed a faction. It is our obligation to provide an atmosphere that is safe embracing and free of any type of discrimination to our sisters and brothers. I have noticed that more organizations are picking up the mantle to secure rights for this afflicted with this illness. There are pastors (23 percent) preaching from the pulpits every Sunday who would never admit they have a mental illness, although in private they have admitted to suffering from some form of it.[88] Twelve percent say they have received a diagnosis for a mental health condition.[89] If the clergy will not recognize mental illness in a positive manner from the pulpit why would the congregants and members of their various communities? It's amazing how the ecumenical body can be so subjective concerning what they will and will not align themselves.

It is going to take the "village" not certain agencies or communities to erase the stigma, hesitancy, and unease associated with mental illness. I was fortunate to have parents that always had a soft place in their hearts for the mentally impaired. This helped me to overcome my early aversion to what I had seen on television, during the closing of remaining (built in the1940's) facilities for the mentally ill on Long Island and the horror stories I heard whispered as a child of mental institutions. We were told constantly as children if we did not modify our behavior the people would put us on the island. I had

[88] Bob Smietana, "Mental Illness Remains Taboo Topic for Many Pastors," LifeWay Research, September 22, 2014, http://lifewayresearch.com/2014/09/22/mental-illness-remains-taboo-topic-for-many-pastors/ (accessed November 20, 2016).

[89] Ibid.

no idea then that the "island" they were referring to was Long Island where those suffering with mental instability were housed. Although it was just a scare tactic used by grandparents and caretakers to instill a sense of control; looking back, how horrible to use another's disability to frighten children into behaving.

When I began this project my goal was to bring awareness to the inhabitants of HALI, and glean a better understanding of the grieving and lack of support for the mentally and how to assist them in healing. The thought would be to develop the same project at Jesus Saves Back to Life, which is my focal point in the Bronx. I believe that has been accomplished, but in addition I have found a passion for a new ministry advocating for the emotionally disturbed in the church. I believe they can serve and be instrumental in proving a sense of unity, thereby giving them a sense of laboring in the vineyard for Christ. We have made great strides in treatments and understanding their plight. People of Christ serve in many capacities and seek respite when they aren't feeling well. Why can't Psychiatric Survivors be afforded the same courtesy? I believe there are many opportunities for them to join the laboring for Christ, as ushers, choir members, culinary assistants and members of the various church ministries. Psychiatric Survivors are at a level of functionally to serve in the preceding manner. However, those who can should be allowed to do so. I have modified a church assessment tool, which can be helpful in initial stages of integrating Psychiatric Survivors into the church.[90]

Though I'm mindful, that whereas headway has been made, we cannot afford ourselves the luxury of assuming a lackadaisical or terminating attitude toward this never-ending cause.

[90]See Appendix Four.

I have come to realize various strength and weaknesses while pursuing this project. The strength is the pastor (Rev. Lang) of Jesus Saves Back to Life as well as the staff and congregants. They are increasing their vast awareness of the spectrum of mental illness and its various stages of functionality and how they affect our community. This has aided them in gaining insight to the role we must assume in advocating for our brothers, sister, and neighbors. HALI has learned the value a grief/loss group can bring to Psychiatric Survivors suffering with grief and loss. This is done while providing a sense of camaraderie during a difficult time. They aspire to have a peer-run loss/grief support group in the near future, one of my goals from the onset.

A major weakness is my lack of education and basic knowledge of my brother and sisters who live in a world that is constantly disregarding and shutting them out. It is painful to know I don't have the tools that would truly aid them in their struggle, yet. Not only myself, but the world at large must move forward to eradicate this plight. We must stop looking at the other person to step up to the plate and stand there with them ready to swing our bat.

Who knows where this project will lead me in the future? Wherever that is, I know there has been an intensification of activism for Psychiatric Survivor community. I will not ignore the call to arms for their cause, my faith demands confidence that the Lord will provide the artillery needed to win the battle if not the war.

Although the church has surpassed itself in supplying the physical needs of the flock, the time has come to focus on the cerebral. The following is an open letter to the church from someone who is challenged with mental illness.

An Open Letter to My Church Family

I am writing this letter to you as a plea for understanding, not only for me, but also for others who suffer with similar illnesses. You are my family in the Lord. I love you, and I know you want to be supportive to me. While I cannot speak for every mentally ill person, many of the statements I make are true for others. A few may be unique to me.

I believe mental illness is today's leprosy. Even in the church, it is shrouded in silence and isolation. Admitting to having a mental illness is a kind of emotional suicide. "Don't talk about it," I have been advised by those closest to me. Deep inside, I know they are right. I did speak out when I was first diagnosed, and I bear the stigma that accompanies mental illness because I did. Being quiet now won't erase that, but maybe if I do speak out, someone will understand. Maybe that someone will be you.

The most important thing to me is that you accept my mental illness for what it is: an illness. It hurts when some of you treat my illness as a character flaw or sin condition. It is just as painful when you pretend nothing is wrong with me and that, if I would just ignore my illness, it would somehow all go away.



Please don't hold out false hope to me. If I had cancer or diabetes, you wouldn't guarantee me God's healing. Don't promise that to me now. I am very aware of God's healing power, but I know God may or may not choose to heal me. As with any illness, he may choose to allow me to experience it instead.

I know God loves me. I believe his promises are for me, including the one that says, "In all things God works for the good of those who love him" (Rom. 8:28). I don't understand why mental illness is part of my life, but I believe my life is in God's hands. Whatever God chooses for me, I want to bring him glory. I am learning to walk daily, holding to his hand, just as you do, only I probably have to cling a little tighter.

One thing I really need from you is your prayer support, but all the warnings I have been given about keeping quiet about my illness make it hard for me to ask. I don't want to dwell on my symptoms, but there are times when I feel overwhelmed by them and I wish I could tell you so without feeling guilty.

You may wonder what to pray for people like me. Pray that my symptoms won't lead me into sin. Pray for my relationships with my family and friends because those close to me suffer with me. Pray that God will help me to be a consistent Christian, despite my illness. Pray that Jesus will be seen in me. Of course, pray for my healing, but also pray that God will help me to accept my illness if healing is not his will for me. Your prayers are the best support you can give me. You and I may never know the depths to which I might have sunk without them.

Being able to serve the Lord is important to me. I owe him a debt of love I never can repay. Before you knew I had this illness, I had many opportunities to serve. I am still the same person with the same talents. Have you lost confidence in me just because you know I have an illness? I am still a capable person. Please don't declare me unfit to serve. Instead, I need your support, a mighty outpouring of prayer, that God will make me equal to any calling he gives me.

As with any illness, I may have to limit myself at times in order to protect my health and to ensure doing my best for the Lord. Please allow me to set my own limits with the help of God, my family, and my doctor. If I see my symptoms are interfering with my service to the Lord or that my health is being adversely affected, I will resign. Pray that God will give me discernment in this area of my life.

While I appreciate your understanding, I don't want you to think you must tiptoe around me. I want your empathy, not your pity. When some of you watch me so carefully for signs of the illness, I know you mean well and only want to help me, but it makes me feel like I'm under a magnifying glass.

Also, everything is not a symptom of the illness; nor can everything be blamed on it. I am responsible for the choices I make, just as you are.

One of the most painful things for me is when someone tries to "help" me control my emotions in front of others. All that does is add embarrassment to my emotional overload. Telling me to "calm down" or "relax" is pointless. If I could, don't you think I would? I don't doubt your motives are pure in trying to help me, but my self-esteem is shattered by that kind of help. The best thing you can do if you really feel I need help in a certain situation is to tell me privately.

The one positive aspect of my illness is the creativity that often accompanies it. At times I get overly excited about ideas I have. One of my greatest frustrations is having my ideas discounted just because of my illness. I would love to be able to present my ideas as matter-of-factly orally as I do in writing, but sometimes I find that difficult. If you can look past my emotions, you will find many of my ideas are good ones. Examine them for their own merit, and then decide whether they are worthy of consideration.

Finally, no letter about my illness would be complete without my giving glory to God for all he has brought me through. Looking back, I can see God's love was reaching out to me even when I experienced the darkest moments of my life. God restored me, giving me more balanced mental health. I don't know what the future holds for me, but I am not afraid. Because God is with me, I have hope for the future in the midst of the uncertainty of my illness. My emotions cannot always be trusted, but my God can. I trust my life to him (©Pathways to Promise, used with permission).
[91]

The focus for my dissertation was to provide the assistance I had been denied during my personal period of grieving. Upon investigation and through a conversation with one of my friends through seminary who had recently lost a sibling, I learned that Calvary had indeed developed a support group for grieving siblings in the latter years since my inquiries. While HALI was an option for a sibling grief/loss support my lack of qualifications gave me hesitancy. I was just becoming acquainted with the Psychiatric Survivor population. I wasn't sure if they would be receptive. After speaking with the executive staff, some of my fears were allayed. To my surprise, my sibling grief/loss project was changed to grief/loss in any capacity. God tends to guide us toward the path we are truly needed. The support group seem to flourish almost overnight the topics, participation and eagerness to share I received from the group gave the project a validity I never expected.

One of the first problems I encountered was a delay of at least 3 months. I never knew fingerprinting was such a rigorous exact process that had to be followed with no exceptions that were not approved by the department of mental health. I truly respect and appreciate their thoroughness when it derives from protecting the rights of those who may or may not be capable. Following that delay, I encountered an unexpected glitch my

[91] Mark Stephenson, "Open Letter to the Congregation," Network, July 1, 2012, http://network.crcna.org/disability-concerns/open-letter-congregation (accessed November 20, 2016).

health. I was hospitalized twice, and I had two severe hand injuries, which restricted my range and mobility, rendering my hand in a state of transient disability. Of course this was my dominant hand that was in temporarily not in use. Following that, I incurred a leg injury that left me on crutches for three months.

As anticipated by the program director, word of mouth was my greatest advocate. The fact that the group enjoyed the direction the sessions was indeed helpful. However a learning point was in the wording of the flyers that were distributed they touted a support group for grief and loss of a physical nature. The flyer actually said loss of persons first and then described other losses. I discovered that many were reluctant to participate because their losses were of a different nature, and they did not feel our group setting would be helpful. Ironically, the support group became centered on a variety of losses that included death of family, friends and pets, loss of relationships with those who are living, loss of dignity and even the loss of Section-8 benefits. The group went into a direction I was not expecting. However, it proved to be quite rewarding. I learned that Psychiatric Survivors have the same problems, dreams and hopes that we experience. Yes, there are times when they may exhibit behaviors that are unbecoming but so do we all at times. I met people who were very well educated and had attended some noted universities as well as having worked at prestigious places of employment. In many cases, they had traumatic incidents in their lives tthat rendered them diagnosed with a mental impairment. In any case, I will continue to be an advocate for Psychiatric Survivors.

APPENDICES

Appendix One

DEMONSTRATION PROJECT PROPOSAL

NO LONGER ALONE IN A CROWD: HOW A MODEL PROGRAM CAN BE UTILIZED TO ADDRESS THE NEEDS OF GRIEVING PSYCHIATRIC SURVIVORS ON LONG ISLAND

BY

Monica Eady

A DEMONSTRATION PROJECT PROPOSAL

New York Theological Seminary

2016

Challenge Statement

As an associate minister at *Jesus Saves Back to Life Ministry* located in the Bronx, which works with Hands Across Long Island (HALI), I have observed a lack of adequate support available for grieving psychiatric survivors who are experiencing difficulty transitioning toward healing. While the HALI organization serves a Long Island community of 130-150 survivors, there are survivors in both Long Island and the Bronx who have not been reached. If this need is not addressed, they may experience traumatic mourning. This demonstration project will design a program model that will assist psychiatric survivors experiencing grief, while creating a confidential and healing atmosphere to be duplicated in the Bronx.

Table of Contents

Chapter 1 ~ Introduction to the Setting.....3

Chapter 2 ~ Preliminary Analysis of the Challenge.....7

Chapter 3 ~ Plan of Implementation.....12

Chapter 4 ~ Research Questions.....14

Chapter 5 ~ Ministerial Competencies.....15.

Chapter 6 ~ Evaluation Process.....19

Chapter 7 ~ Appendices.....21
A -Timeline.....21
B - Budget.....23

Bibliography.....25

Chapter One

INTRODUCTION TO THE SETTING

As a transplant minister from the borough of the Bronx to Long Island, the opportunity was presented for me to work at *Hands Across Long Island* (HALI), a grass-roots, multi-service organization formed in 1988. It is the first mental health clinic both managed and operated by and for psychiatric survivors in the United States. Today, HALI is the largest and most successfully peer run multi-service mental health organization in New York State, helping over 35,000 consumers each year. HALI helps survivors/consumers empower themselves, by focusing on what people ***'can do'*** as opposed to what they cannot do. When survivors are meeting their responsibilities and taking pride in making personal choices, they are escaping the stigma, isolation and shame surrounding mental illness. This process of empowerment is in essence helping them lead fulfilled lives. As their website states, "HALI works with the expectation that people CAN and DO RECOVER, work, have meaningful relationships, become contributing members of their communities and lead lives worth living. HALI believes that people receiving services are not patients, but **PEOPLE WITH POTENTIAL**."[1]

Hands Across Long Island has two sites. There is one located in Jamaica, New York and one located in Central Islip. The Central Islip site is the one to which I am affiliated. This particular site consists of one long building with two separate entrances. Both entrances are located in the front portion of the structure. The exterior is painted white with blue trimming. The street is a mix of both commercial and residential

[1] "About Hali," Hands Across Long Island, accessed September 19, 2016, http://www.hali88.org/about-us/.

occupancies: The Victoria Bakery, Iglesias De Dios Camino Salvation (church), Allstate Carburetor, Tri-State Tire and Wheel Alignment along with private homes.

From the exterior, HALI looks similar to any other storefront, which is an assumption that is quickly abolished once you step inside the front door. Immediately, you are welcomed with the buzz of activity, smiling faces, and the warm connections between and among the people. It is literally physically palpable; it warms your soul and puts a smile in your heart. Inspiring messages of hope are seen everywhere, like Bob Marley's "You just can't live in that negative way…Make way for the positive day."[2]

Even with the warm and welcoming atmosphere, there is a strict security policy that requires all visitors entering the HALI premise to login. The receptionist, who inspects your identification and to whom you state your reason for visiting HALI, greets everyone. If you have an appointment, you must be seated until the person you are visiting is ready to receive you. The reception area is brightly decorated denoting holidays and seasons. Religious holidays are also noted in the hallways and glass cases that line the corridor. The building has more length than width. There are approximately thirty rooms, which house the staff, medical, maintenance offices and classrooms. The lighting tends to be mild, except in the Great Room, which is serves as a community room, dining room and a conference room.

HALI was established from the experiences of a community member and her family who felt painful isolation and stigma following a mental health hospitalization. It has been under the leadership of Ellen M. Hellion since 1993. As Chief Executive Officer, Ms. Hellion has lead this organization in such a way that it has steadily evolved

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[2] "Bob Marley Lyrics: Positive Vibration Lyrics," METROLYRICS, accessed September 25, 2016, http://www.metrolyrics.com/positive-vibration-lyrics-bob-marley.html.

from initially weekday drop-in centers to Personalized Recovery Oriented Services (PROS), supported housing, advocacy, a resource center which consists of a lending library and a computer lab and consultation services.

Currently HALI provides Supported Housing to over 150 individuals in Nassau and Suffolk Counties. In addition to rental subsidies, HALI case managers provide regular visits with the tenants to assist them in a multitude of activities from daily living skills, to employment and the acquisition of benefits. The housing is available through Single Point of Access (SPA) referrals for individuals with mental illness are independent in maintaining. (Transformation, Recovery and Resilience).

In 2009, HALI blazed new trails by building a home with private two-room spaces for each resident with shared common interests promoting a sense of independence and well-being. At HALI, each applicant is interviewed and has the opportunity to meet with potential housemates to ensure there is a match in personalities prior to placement in the home. This project was a true community endeavor. Support from the State Senate, Suffolk County, towns and neighbors made this possible. The Central Islip home, targets homeless individuals who have additional physical issues. HALI assists with obtaining home health care services, if eligible.

There has been a spotlight recently on the church's seemingly detached stance on aligning itself with the mental illness community. This has resulted in a great deal of dialogue concerning what clergy can do to offer solace, care and our unwavering support to psychiatric survivors. As a member of the clergy, I recognize that we cannot rectify the wrongs of our past; but we can work toward improving our future relationship with the mental illness community. Jesus Saves Back to Life Ministry is noted for their

commitment to the community, which began with focusing on youth and young adults it has been observed that some of the youth and young adults that have been a part of the ministry have suffered with mental illness or have family members who suffer from the same malaise.

The location of the Jesus Saves ministry is in the South Bronx where vestiges of mental illness have shattered many lives. Having been a former resident of the Bronx, I was able to witness the lack of mental stability impede neighbors' and acquaintances' opportunity to receive the services needed to assist them. Hopefully, the skills I acquire will not only assist the clients of HALI but will be helpful to the community of Jesus Saves as well.

Working in HALI has made me very much aware of the lack of spirituality available for the participants. I am presently implementing a "Grief/Loss Program," which for me as a minister, is based upon spirituality. Ironically, that is probably going to be my greatest challenge, trying to help others find God without actually using the terminology denoting "Him" as such. Having always come from a Bible based faith-community, spirituality and God are simultaneous as far as I am concerned. I'm sure it will take a bit of innovation and creativity on my part to achieve a successful healing, peer-oriented grief /loss support group at HALI.

Chapter Two

PRELIMINARY ANALYSIS OF THE CHALLENGE

Challenge Statement

As an associate minister at *Jesus Saves Back to Life Ministry* located in the Bronx, which works with Hands Across Long Island (HALI), I have observed a lack of adequate support available for grieving psychiatric survivors who are experiencing difficulty transitioning toward healing. While the HALI organization serves a Long Island community of 130-150 survivors, there are survivors in both Long Island and the Bronx who have not been reached. If this need is not addressed, they may experience traumatic mourning. This demonstration project will design a program model that will assist psychiatric survivors experiencing grief, while creating a confidential and healing atmosphere to be duplicated in the Bronx.

Grief/ loss has touched the psychiatric survivors in the much same manners as the surrounding communities. As a result of the escalating crime rate, loss of employment, shattering marriages, loss of companionship (including the loss of pets) and loss of dignity, many in the community are feeling isolated and alone. As minister working with lower income families, I have intimate knowledge of the devastating effects such tragedies wreak upon families, which include psychiatric survivors. The HALI organization expressed their concern of the lack of support available to their community and the need for intervention. During this time there was the loss of a staff member, which had a traumatic effect on the community at large. Shortly after, there were a number of deaths within the community from illness, as well as, one murder. The emotional turmoil of the participants was very heart wrenching, as they tried to seek comfort in the one place they all considered a second home.

The organization was very sympathetic to the emotions of the community. Social workers psychiatrists and medical doctors well as various staff members spent time trying

to assist through their crisis. The work schedules of the staff did not allot the time frame needed to assist in transition from grief/loss to healing nor, would they be able to work-one-on one to facilitate reconciling and be effective in their daily duties at HALI.

Although the needs to for grief/ loss support has certainly been thrust to the forefront since for the last 20 years, the psychiatric survivors seemed to have been forgotten in the attempts to offer reconciliation/curative measures for the mourning community. Loss is a part of life, and grief is a natural part of life the healing process. The reasons for grief are many, such as the loss of a loved one, the loss of health, or letting go of a long held dream. Dealing with a significant loss can be one of the most difficult times in a person's life. There are different types of loss, feelings of loss are very personal and only you know what is significant to you. People commonly associate loss with strong feelings of grief. These can include:

- Lose of a close friend
- Death of a partner
- Death of a classmate or colleague
- Serious illness of a loved one
- Relationship breakup
- Death of a family member

Subtle or less obvious losses can also cause strong feelings of grief, even though around you may not know the extent of your feelings. Some examples include:

- Leaving home
- Illness/loss of health
- Death of a pet

- Change of a job
- Move to a new home
- Graduation from school
- Loss of a physical ability
- Loss of financial security

Jesus Saves Back to Life (ministry/congregation) of which I'm a part of, is located in the South Bronx, which houses many impoverished families. The people who reside there have limited access to the healthcare (mental) service which could be conducive to their well-being, due to finances, lack of knowledge or limited assimilating abilities. The mission of Jesus Saves is to guide people to God, with a special focus on youth and young adult ministries. Our main focus is on the spiritual well being of the people we serve. We believe that with God's strength, families will be able to communicate openly and honestly to solve problems. We plan to work with community and government leaders to address the needs and concerns of our communities. We hope to bridge the gap in communication between the generations. We plan to put into place educational programming, which will aid our community in taking education off of the back burner and bring literacy concerns to the forefront. We would like to in time establish a scholarship fund to help deal with the astronomical cost of higher education. We plan to develop creative ministry efforts such as drama, rap and liturgical dance. We believe that by giving our youth and young adult's variety we may find something that holds their interest and keeps them out of trouble. We want to build leaders for tomorrow, because without leadership we falter.

Although the churches initial focal point was the youth and young adults in the area, adults ultimately gained inclusion. Jesus Saves now has expanded its focus to include all in need. However, the psychiatric sector in the grieving process seem so be left out of all the regenerating and developing being implemented in those communities today. Presently the church as well as political advocators in the South Bronx seems to be absent or clueless to the plight of psychiatric survivors need for grief/loss support recalibration in their own communities. There have been great strides made by those suffering with mental illness with the proper grieving loss support in various locations. Although as a minister connected to a ministry in the south Bronx, while working at HALI in Central Islip, my reach is limited. Yet, my goal is to transform an entire community simply by helping one person at a time to receive the support they need. And be able to assist those going through their mourning period with peer support. Hopefully, this will evolve into peers acquiring the skills to facilitate a grief/loss support group.

Peer support leadership is part of the independent living model, which allows expression of people's desire to be in control of their own lives. When you are a part of a peer support group (especially grief/loss) you realize how important it is for a person with a mental disability to have the experience of meeting and talking with another person with a disability. It opens up the recognition of the uniqueness of their experience.[3]

If I can facilitate in creating a peer/support group within the HALI community and then duplicate the model with the Jesus Saves ministry community, hopefully this will elicit the necessity to take a second look at a vital part of our communities that is

[3] "Supporting Others Who Are Grieving," CMHC UT Counseling and Mental Health Center Division of Student Affairs Grief and Loss, accessed September 26, 2016, https://cmhc.utexas.edu/griefloss.html#supporting.

being overlooked along with spurring an agent of change within the church to support and protect our most vulnerable.

I have been given the support of the HALI community. They have graciously assigned a meeting area that is confidential, comfortable and quiet for our meeting space. HALI assists in any way they can to assist with my project. My prayer is that the model program created for HALI will be just as successful when duplicated for Jesus Saves Ministry and will encourage healing from grief/loss.

My Site Team has expressed enthusiasm for the project and is determined to make a difference in the lives of our most vulnerable during their transition from grief/loss to healing. The one challenge in the foreseeable future is our consistent use of the Christian titles for our Creator, which is restricted within the HALI organization.

Chapter Three

Plan of Implementation

Goal 1
To bring awareness to the churches communities as well as the HALI community to the lack of Grief, Loss and healing recovering support groups; accessible to Psychiatric Survivors.

Goal 1 Strategies:

A. Community workshop facilitated by members of Loss/Grief support group.

(Site Team, closed group, myself)

B. Targeting an audience of participants within the targeted community who have experienced Loss/Grief and are struggling to recover. (Site Team, Myself)

C. Create a skit that will incorporate various humanistic feelings, participant's experience, as a result of Loss/Grief; while illuminating the need for sufficient support groups. (Site Team, closed group, myself)

Evaluation of Goal
Prior to each event I would have the participant's assessing 4-5 of their peers in regard to their understanding of Grief/Loss and recovery. At the conclusion of there will be role reversal, those interviewed will become interviewers to those they initially interviewed.

Goal 2
To formulate a team from within/outside the community that will assist in accomplishing these goals in an organized and structured manner.

Goal 2 strategies:

A. Orientate group to assure the alignment of the vision. While reviewing processing and developing strategies for the goal.

(Site Team, Myself)

B. Develop guidelines to assist the closed group in focusing on the intended direction.
(Site Team, Myself)

C. Team must have general knowledge of the community, which they are serving.

Evaluation of Goal
Engaging a group of survivors and their peers to see their vision for moving forward. Mid-way through the project we will regroup to see what has been effective and what has not. During that time an evaluation will be done to determine what has and has not been

beneficial. There will also be a decision as to what improvements can be made. The effectiveness of the processes will be determined by consensus of 3/4 of the team.

Goal 3
Conduct statistical research on Loss/Grief within the community as a pivotal point to identify the need for a safe and confidential environment.

Goal 3 strategies:

A. Use of Site Team to assist in developing an instrument to gather statistical information.

B. Identifying resources required in order to be able to attain information.

C. Gather information in order for data to be presented in a structured, as well as, formable manner. This information is imperative to engage the targeted audience.

Evaluation of Goal

Will seek comments and feedback from team leader chosen by the team after an over-all consensus, of 3/4 the team, which would determine, what strategies would be implemented.

Goal 4
Assist group in becoming a peer facilitated support group that will promote healing within their community

Goal 4 strategies:

A. Create a specified account of the criteria needed to implement the support group.
B. Compose a detailed description of the individual who would fulfill the requirements for group facilitator.

Evaluation of Goal
Will solicit critique from the participants, team and the community strategies we have selected for in-put.

Chapter Four

RESEARCH QUESTIONS

Research Question 1: (Biblical)

Has there been a misconstruing of biblical themes, scriptures or comprehensions that have caused psychiatric survivors to feel neglected and detached from spiritual grief/loss healing? Which Biblical stories speak to psychiatric survivors in the twenty-first century? What can current biblical scholarship offer as a resolution to grieving psychiatric survivors seeking healing?

Research Question 2: (Social Economic)

How do the current social, political, economic trends of the millennium affect psychiatric survivors experiencing grief/trauma? Who are their representatives and advocates? Who should be on the forefront of designing the social/economic model appropriate for the survivors?

Research Question 3: (Historical)

What has been the history of grief/loss for psychiatric survivors in the Central Islip area (HALI)? What has been the level of involvement of community leaders, advocates, and government involvement? What, if any, practices have been implemented to prevent this downward spiral of emotional trauma and how has it affected the community?

Chapter Five

MINISTERIAL COMPETENCIES

Competencies for DMin Student: Monica Eady
As reviewed by Site Team
Friday, July 24, 2015

After a careful review of Minister Monica Eady it was decided by the Site Team that Monica Eady would work on these areas:

As Theologian:

After careful assessment we concluded that Monica Eady has proven to be consistent in the scriptures, has received formal training, has the ability to relate and engage in the scriptures to make it relevant for today.

As Preacher:

After careful assessment we concluded that Monica Eady has proven herself as preacher, however, it was suggested that she continue to work on her delivery.

As Worship Leader:

After careful assessment we concluded that Monica Eady has proven herself as worship leader, however, it was again suggested that she should continue to work in this area.

As Prophetic Agent:

After careful assessment we concluded that Monica Eady as prophetic agent, is committed to see change in the world, has the ability to diagnose the roots of social problems, is emphatic to what is going on in the world, and his will to take risks to see social change.

As Counselor:

After careful assessment we concluded that because of her project and the work she would like to do with those who are in the bereavement process, Monica Eady should engage in classes in counseling to become stronger in the work she has committed herself to.

As Pastor:

This does not pertain to Monica Eady, no assessment available.

As Spiritual Leader:

After careful assessment we concluded that Monica Eady presents herself as a strong spiritual leader, effective at leading and guiding the people, attentive to her spiritual journey always looking to grow. However, we all concluded that Monica needs to practice more self-care.

As Ecumenist:

After careful assessment we agreed that as Ecumenist Monica Eady has a strong knowledge of engaging other faith traditions and is open to hear and examine other faith traditions.

As Witness or Evangelist:

After careful assessment we agreed that Monica Eady has proven to be a faithful witness and evangelist as she has been available to both her family, friends, community and faith community in their times of need.

As Administrator:

After careful assessment we agreed that Monica Eady needs to stay more focused on her tasks to be sure she makes deadlines.

As Professional:

After careful assessment we agreed that as professional, Monica Eady has proven herself as a positive and dependable individual in regard to self and others. She is personable and has a great deal of integrity.

As Financial Manager:

After careful assessment we agreed that Monica Eady understands financial matters, but can always improve by learning and understanding church financial management.

As Technological/Social Media Management:

This is an area that we agreed that Monica Eady should receive more training.

Summation:

After careful consideration we chose two competencies that we feel Monica Eady should engage in counseling classes to become better prepared for a bereavement

ministry as well as administrative skill set that will ensure her staying focused on her tasks.

The three competency areas my site team felt would provide me with development and the potential to hone my proficiencies, and at the same time provide an excellent foundation to enrich the ministerial skills needed to create an applicable demonstration project are listed below:

Pastoral Care has a focus on Physical/Spiritual healing. While emphasizing relational responsibilities, love of neighbor, love for self; which is critical to human wholeness. An important component of Pastoral care is to give support to congregations and their leaders in the ministries of health and healing while enhancing people skills. Theologically my nucleus will be interpreting life's chronicles in the framework of God's love and justice as perceived through scripture and practices of faith communities.

Counseling- My intent is to increase my listening skills during dialogue, examine literature on the subject (listening) matter, monitor grief support group, interview grief/loss care and counseling directors. Attendance in a course on Greif/Loss and Dying will also be included.

Ascertain the necessary tools/skills to minister constructively and effectively regarding conflict and resolution

Spiritual Leader leads by example. I will develop a self-care regime. Self Care is contingent on constructing a luminous spiritual life through consistent prayer and research. It includes but is not limited to personal reflection, scripture, fasting, private retreats, confession, seeking spiritual direction, creating a personal Sabbath. I will be practicing in the presence of God's empowering grace. I will embark on a regime of

physical exercise, conditioning and nutrition. Indulging in spa dates, spending time in parks embracing God's awesome creations. I will be embracing family vacations, while creating boundaries for ministry and respite.

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Chapter Six

EVALUATION PROCESS

This evaluation will be a structured process of accessing the success of a project in meeting its goals and to reflect on information gathered.

There will be an evaluation based on the prior and concluding knowledge the participants and staff have gleaned from the support group events. This will be helpful in measuring our progress. The team and I will be surveying the aforementioned groups, and assessing whether or not they found the gatherings beneficial.

Upon reviewing the attendance and level of engagement of the group participants, we will ascertain whether the strategies being used are effective or not. A criteria of monitoring, used will seek a response from the group to ascertain the necessary steps needed to improve support group participation.

Moving forward, we will seek feedback from the community in the form of a Questionnaire, which will in turn, be able to help us determine if we are being helpful or adversely, a hindrance in our quest to find out how we can amend our program to meet the specific needs of participants. We will have an impartial individual, selected by the team, whose main responsibility, will be to monitor our timeline and budget.

Chapter Seven

APPENDICES

Appendix A

TIMELINE

DATE	TASK/ACTIVITY	TOOLS TO COMPLETE TASK	PERSON RESPONSIBLE
Upon Approval-1/10/16	Initial meeting with my Advisor	Project Approved	Min. Monica Eady
2/15/11	Create the Criteria for Team	Venue- Refreshments	Site Team, Min. Monica Eady
3/4/16	Have orientation with Team	Venue-Refreshments	Min. Eady
3/7/16-5/9/16	Annual Bereavement (Calvary Hospital) Hospital		Min. Eady
4/6/16-5/25/16	8-week support group Meetings	Venue-Refreshments	Site Team, Min, Eady
4/13/16-5/20/16	Focus Group Sessions on research to develop strategies for programming	Venue	Site Team, Selected Team, H.A.L.I Program Director(social workers) Min. Eady
5/20/16	Team will tour community. Team will assess Site and Program.	Notebooks, Pens	Selected Team
5/31/16	The Play- Alone in a crowd	Paper, Computer, Writer, Printer, and Printer Ink	Min. Eady, Selected Team, H.A.L.I. Staff
6/15/16	Group Session with Psychiatric Survivors in community for feedback on strategies selected	Venue	Min. Eady, Site Team
6/21/16	Meet with my Advisor	Summary of Progress	Min. Eady
6/30/11	The study on the history Psychiatric Survivors in Suffolk County	Books, Periodicals, Journals, The Census, County Records	Site Team, Min. Eady
7/1/11	Celebratory Luncheon (Finale) for Support Group	Venue-Refreshments, Decorations, Gifts	Min. Eady, Hali Staff,

DATE	TASK/ACTIVITY	TOOLS TO COMPLETE TASK	PERSON RESPONSIBLE
9/28/16	Meet with my advisor	Summary of progress	Min. Eady
10/15/16	Begin structuring notes, data	Computer, books, paper, pens, pencils	Min. Eady
10/29/16	Write detailed description for facilitator of the group	Notebooks, Pens	Selected Team, Site Team, Min. Eady
11/15/16	Write detailed description for the support group	Notebooks, Pen, Pencils	Selected Team, Site Team, Min. Eady
11/29/16	Meet with my advisor	Summary of Progress	Min. Eady
12/14/16	Seek an Editor	Summary of progress	Min. Eady
1/13/16	Meet with my advisor	Summary of progress	Min. Eady
1/28/16	Complete writing for submission	Computer, paper, books	Min. Eady
2/1/16	Give completed project to Editor for Review and Editing		Min. Eady
2/6/16	Complete Evaluation Process	Surveys, Compilation Attendance sheets, Interviews	Selected Team, Site Team, Min. Eady

Appendix B

BUDGET

Date	Task/Activity	Tools/Necessary to complete task	COST/FUNDING
2/15/16	Create the Criteria for Team	Venue-Refreshments	$ 50.00
3/4/16	Have orientation with Team	Venue-Refreshments	$ 50.00
3/7/16-5/9/16	Annual Bereavement (Calvary Hospital) Hospital		$250.00
4/6/16-5/25/16	8-week support group Meetings	Venue-Refreshments	$200.00
4/13/16-5/20/16	Focus Group Sessions on research to develop strategies for programming	Venue	$100.00
5/20/16	Team will tour community. Team will assess Site and Program.	Notebooks, Pens	$25.00
5/31/16	The Play- Alone in a crowd	Paper, Computer, Writer, Printer, and Printer Ink	$50.00
6/30/16	The study on the history Psychiatric Survivors in Suffolk County	Books, Periodicals, Journals, The Census, County Records	$300.00
7/1/16	Celebratory Luncheon (Finale) for Support Group	Venue-Refreshments, Decorations, Gifts	$200.00
10/15/16	Begin structuring notes, data	Computer, books, paper, pens, pencils	$200.00
10/29/16	Write detailed description for facilitator of the group	Notebooks, Pens	$50.00

Date	Task/Activity	Tools/Necessary to complete task	COST/FUNDING
1/28/17	Complete writing for submission	Computer, paper, books	50.00
2/1/17	Give completed project to Editor for Review and Editing		$1000.00 – 1500.00

Approximate Budget Total: $2525 - $3025

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Appendix Two: **DSM-5 LIST OF MENTAL DISORDERS**

Psychology Charts

DSM-5 List of Mental Disorders

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The DSM-5, scheduled for publication in 2013, will be the latest version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. Note: This chart lists major disorders only and is not meant to be comprehesive. See also: Personality Disorder Symptoms

DSM-5	DSM-IV / ICD-9	Disorder Name	Description
A - Neurodevelopmental Disorders			
A05	299.00	**Autism**	The three main characteristics of autism are: 1. impaired social development, 2. diminished communication skills, and 3. restrictive/repetitive behavior. The disorder is highly variable and is now described in terms of a **spectrum** rather than a set of discrete categories. For example, **Asperger's**, once classified separately, is now considered by many experts to be a form of high-functioning autism. Males are 4 times more likely to be autistic than females.
A06	314.00	**ADHD**	ADHD (formerly known as ADD) stands for **Attention Deficit Hyperactivity Disorder** and in most cases is characterized by: 1. a difficulty in focusing one's attention on a single task , and 2. a tendency towards hyperactivity and impulsive behaviors (although some individuals are *either* predominantly inattentive *or* predominantly hyperactive-impulsive). **Ritalin**, a stimulant, is well known as being a common drug used to treat ADHD, particularly in children. 
A08	315.00	**Dyslexia**	Dyslexia is a very broad term defining a **learning disability** that impairs a person's ability to read. It is not connected in any way with intelligence.
A11	307.23	**Tourette's**	Tourette's is characterized by sudden urges to engage in a repetitive behavior (called a **tic**) such as blinking one's eyes or smacking one's lips . Although usually associated with uncontrollable swearing, this form of the disorder (known as **Coprolalia**) is actually quite rare.
B - Psychotic Disorders			
B08	295.00	**Schizophrenia**	Schizophrenia is a serious mental illness characterized by auditory hallucinations, paranoia, bizarre delusions, and/or disorganized thinking. It should not be confused with multiple personality disorder (now called dissociative identity disorder), described below. 
C, D - Mood Disorders			
C00	296.50	**Bipolar Disorder**	Previously known as **Manic-Depression**, bipolar disorder is characterized by episodes of significantly elevated mood, arousal, and/or energy levels (mania) often interspersed with contrasting episodes of low mood (depression). It is often noted that there is a significant association between bipolar disorder and **creativity**
D02	296.30	**Clinical Depression**	Also known as **Major Depressive Disorder** or **Unipolar Depression**, this type of recurrent depression is characterized by an all-encompassing low mood, diminished self-esteem, and a loss of interest in normally enjoyable activities. Often misunderstood as being something that individuals should be able to overcome by will-power alone, major depression often requires antidepressant medication such as an **SSRI** (Selective Serotonin Reuptake Inhibitor). 
E, F, G - Anxiety Disorders			
E01	300.01	**Panic Disorder**	A panic attack is a short period (usually 5-10 minutes) of intense fear that comes on suddenly and is characterized by symptoms such as an increased heart rate, shortness of breath, dizziness, numbness, and changes in body temperature. Individuals with panic disorder have recurring panic attacks and often the fear of the attacks themselves become the focus of their anxiety. Panic Disorder often occurs together with **Agoraphobia** (E02), the fear of public places.
E03	300.29	**Phobias**	A phobia is a persistent fear of a certain object or situation in which the individual goes to great lengths to avoid the object or situation in a way that is irrational and disproportional to the actual danger posed. Common phobias include a fear of insects, dogs, boats, needles, airplanes, elevators, etc.). **Social Anxiety**

			Disorder (E04) is a special type of phobia in which the individual has an extreme fear of social interaction.
E05	300.02	**Generalized Anxiety Disorder**	Generalized Anxiety Disorder (often shortened to **GAD**) is characterized by disproportionate worry about everyday things (such as money, health, or relationships) that is ongoing and uncontrollable. It is often expressed in the form of headaches, fidgeting, nausea, irritability, fatigue, or insomnia. 
F00	300.30	**OCD**	OCD stands for **Obsessive-Compulsive Disorder** and is characterized by uncontrollable thoughts (obsessions) that lead to repetitive behaviors (compulsions) aimed at relieving the anxiety brought on by those thoughts. Common compulsions include excessive handwashing, repeated checking, nervous rituals, or extreme hoarding. Unlike those with Obsessive-Compulsive Personality Disorder (OCPD), individuals with OCD often recognize that their obsessions are irrational and therefore experience greater anxiety and feelings of helplessness.
G03	309.81	**PTSD**	PTSD stands for **Post-traumatic Stress Disorder** and can develop after exposure to extreme trauma such as sexual abuse, physical assault, or certain wartime experiences. Symptoms include flashbacks, nightmares and hypervigilance. Prolonged exposure to trauma in which there was no viable means of escape can lead to a distinct but related disorder known as **Complex Post-traumatic Stress Disorder** (C-PTSD)
H - Dissociative Disorders			
H00	300.60	**Depersonalization Disorder**	Depersonalization Disorder is characterized by frequent feelings of detachment from oneself combined with an awareness of the detachment. To someone experiencing depersonalization, the external world feels strange and unreal and a person can even get the sense that they are watching themselves from a third person perspective. However, unlike in psychosis, the individual remains very much aware of their own existence and is, in fact, **overly** aware of it. For this reason, depersonalization disorder is often associated with the philosophy of existentialism.
H02	300.14	**Dissociative Identity Disorder**	Formerly known as **Multiple Personality Disorder** (MPD), Dissociative Identity Disorder (DID) is a controversial diagnosis in which an individual has two or more distinct personalities, each with their own memories and patterns of behaviour. The development of these multiple personalities is a coping mechanism caused by extreme trauma or abuse at an early age (prior to when a sense of a unitary self forms). 
J - Somatic Disorders			
J01	300.70	**Illness Anxiety Disorder**	A person who suffers from Illness Anxiety Disorder is commonly known as a **hypochondriac**. Such as person constantly worries about their health even when they have no reason to do so and often any minor symptom is perceived as being a sign of a serious illness.
J02	300.11	**Conversion Disorder**	Formerly known as **hysteria** (a common 19th century diagnosis made exclusively in women), conversion disorder occurs when patients suffer apparently neurological symptoms -- such as numbness, paralysis, or fits -- but without a neurological cause. The term originates in Freud's belief that, in such cases, a person's anxiety is being 'converted' into physical symptoms.
K - Eating Disorders			
K03	307.1	**Anorexia Nervosa**	**Anorexia nervosa** is characterized by a distorted self-perception and an irrational fear of gaining weight resulting in excessive food restriction and extreme weight loss. It usually develops during adolescence and early adulthood and can lead to serious metabolic and hormonal problems. 
K04	307.51	**Bulimia Nervosa**	Bulimia nervosa is characterized by **binging** (eating a large amount of food in a short amount of time) followed by **purging** (an attempt to rid oneself of the food consumed -- typically by vomiting, taking a laxative, and/or exercising excessively). The binge/purge cycle is often followed by periods of fasting.
M - Sleep Disorders			
M02	347.00	**Narcolepsy**	Narcolepsy is a chronic sleep disorder characterized by excessive sleepiness and sudden sleep attacks at inappropriate times during the day. People with narcolepsy usually also experience disturbed night-time sleep (**insomnia**). It is related to **cataplexy** -- a sudden but short-lasting loss of muscle tone, often triggered by emotions
Q - Impulse Control Disorders			
Q00	313.81	**Oppositional Defiant Disorder**	Oppositional Defiant Disorder, or **ODD**, is characterized by an ongoing pattern of anger-guided disobedience and defiant behavior toward authority figures which goes beyond the bounds of normal childhood behavior
Q02	312.32	**Conduct Disorder**	Some examples of conduct disorder include **kleptomanics**, who suffer from an uncontrollable urge to steal items even though they do not need them (nor even lack the money to pay for them), and **pyromanics** who deliberately start fires for gratification or relief.
T - Personality Disorders			
See: Personality Disorders DSM5			



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Appendix Three: PROJECT FLYER

YOU ARE NOT ALONE!

WE ARE TALKING TO YOU: MOTHER, FATHER, SISTER, BROTHER, COUSIN, AUNT, UNCLE, NIECE, NEPHEW & FRIEND…

WE WILL ALL EXPERIENCE LOSS AT SOME POINT IN OUR LIVES….

THE LOSS OF….

A PERSON – RELATIONSHIPS- PET- A DREAM…

Please join us as we move from Loss/Grief to Healing

THE LOSS SUPPORT GROUP
HANDS ACROSS LONG ISLAND
159 BRIGHTSIDE AVENUE
CENTRAL ISLIP, NY
(631) 234-1925
WEDNESDAYS
12PM -1PM

FACILITATED BY: MINISTER MONICA EADY, M.Div.

JESSE SMITH, CPRP, PROGRAM DIRECTOR



Church Assessment

Yes = 2 To Some Degree = 1 No = 0

1. Is your church a safe community where people can be honest with themselves, each other, and with God?
2. Is your church community a place where feelings, both "good" and "bad," can safely be experienced and expressed?
3. Is your church community one in which people listen, attend, and process rather than simply tell, influence, and give?
4. Does your church community allow people to express their pain?
5. Does your church community encourage and facilitate self-disclosure?
6. Does your church community, both individually and collectively, provide people opportunities to give feedback on their experience in the church?
7. Does your church community extend grace and forgiveness when people are in pain, are different, or fail?

Your Score: ___/14

Prayer:
Lord, thank you for the opportunity to start talking about a topic that is hard to talk about. Some of us might secretly be dealing with it, and it's lonely, Lord. Help us learn what it is that you want to teach us in order that we might learn to care for those among us and their families who experience mental illness. Grant us your grace to respond with compassion. Amen.

Appendix Five
ABOUT HANDS ACROSS LONG ISLAND (HALI)

HANDS ACROSS LONG ISLAND
159 Brightside Ave.• Central Islip, NY 11722
tel. 631.234.1925 • fax. 631.234.7258 • www.hali88.org

HANDS ACROSS LONG ISLAND (HALI) was formed in 1988 as a grass-roots, multi-service, organization managed and operated by, and for, psychiatric survivors. Today, they are the largest and most successful consumer-run, multi-service, mental health organization in NY State, helping over 6,500 consumers each year.

HALI has been quietly and effectively helping survivors empower themselves to lead more productive lives. Focusing in on what people can do, rather than what they can't do. Helping others take pride in making personal choices, meeting responsibilities and escaping the stigma, isolation and shame surrounded by mental illness for centuries. Once they come to HALI, people become responsible for their own recovery, and statistics have shown that it works, with dramatic decreases in hospital stays.

HALI promotes independent living, peer support, advocacy, socialization, education, vocational opportunities, as well as spiritual and emotional growth. They help facilitate over 30 self-help groups throughout Suffolk County providing programs in self help, facilitatory training, computer training, double-trouble in recovery, patient advocacy, emotional support, pre-arrest, consumers with conviction, transportation, information & referral services, dances, holiday celebrations, dream makers band, DJ & recording services, food co-ops, music, supported housing, apartment readiness, forensic services, self directed rehabilitation, bi-county consumer conferences, mental health walks, community kitchen and will also be collaborating on programs with the Suffolk County police.

HALI has many future goals and will continue to create vital programs which will provide empowerment, strength and recovery for all who need it.

for further information please contact HALI or Jill Fifield 631.969.0185

Appendix Six
HANDS ACROSS LONG ISLAND MISSION AND VISION STATEMENTS

Hands Across Long Island, Inc.

Mission Statement: HALI is a peer community providing the opportunity for recovery from mental illness through collaborative creative efforts.

HALI Values Statement: Hands Across Long Island, Inc. strives to excel and believes strongly in the capacity of others to excel. People are the bedrock of organizations, and we invest in human potential- in ourselves, in community leaders with vision and passion, and in individuals and communities dedicated to transforming themselves. We value efforts where those who benefit have the chance to shape their own path to self-determination, and we help them create their own opportunities where barriers often exist.

HALI Vision Statement: Hands Across Long Island will continue to create vital programs which provide empowerment, strength, and assistance in the recovery process of psychiatric consumers and survivors. Our vision for the future includes:

- Creating a technical program to provide the replication and expansion of "HALI" and it's successes to other counties and agencies on Long Island, as well as other states across the country. This will include consulting and technical assistance services offered to other mental health organizations to facilitate the successful creation and implementation of programs utilizing self help and empowerment techniques.
- Increasing housing opportunities.
- Purchasing homes and creating services to meet the needs of individuals diagnosed with mental illness.
- Building "Corporate Partnerships" to create vocational opportunities for individuals to re-enter the workplace.
- Using web services, computers, and the internet to develop a communication system that will help to bridge the isolation of homebound consumers.
- Publishing and distributing research and statistical outcomes that show the effectiveness of HALI's methods to a wide range of persons and affiliations.
- Sharing our personal experiences with high school and college students to cultivate understanding that will bring about positive and informed responses to mental illness and ultimately effect widespread change.
- Establishing a grant fund for individual(s) and/or group peer initiatives for entrepreneurial and education purposes.
- Establishing an holistic respite center to provide a short-term haven for individuals to avoid hospitalisation.
- Expanding our homeless prevention program by engaging at-risk individuals in communal activities that increases stability and diminishes isolation.
- Organizing and providing educational lectures in workplaces, and civic settings to hasten the process whereby awareness replaces stigma in our society.
- Expanding our forensic services by bridging more individuals leaving correctional facilities back to their communities all across New York State.
- Providing integrated treatment and better support systems for individuals with a dual diagnosis.
- Active involvement in advocacy efforts that will effect policy changes.
- To be the premier provider of mental health services for the growing senior population.
- Promoting healthier life styles through education and wellness self management by focusing on the whole person.
- To provide peer mentoring to young adults aging out of children's mental health services and tailoring those services to meet their unique needs.
- Fostering an environment that promotes the belief that recovery is possible.
- Opening the first peer run clinic in the United States.
- Providing a comprehensive rehabilitation based approach to the delivery of mental health services called HALI U.
- The HALI U model will change the manner in which mental health care is provided in this country.

Appendix Seven
HANDS ACROSS LONG ISLAND PROGRAMS

HANDS ACROSS LONG ISLAND

HANDS ACROSS LONG ISLAND (HALI) was formed in 1988 as a grassroots, multi-service, organization managed and operated by, and for, psychiatric survivors. Today, we are the largest and most successful peer-run, multi-service agency, mental health organization in NY State, helping over 3,500 consumers each year. HALI operates the FIRST peer-run mental health clinic in the United States.

Mission Statement:

HALI is a peer community providing the opportunity for recovery from mental illness through collaborative creative efforts.

Values Statement:

Hands Across Long Island, Inc. strives to excel and believes strongly in the capacity of others to excel. People are the bedrock of the organization, and we invest in human potential - in ourselves, in community leaders with vision and passion, and in individuals and communitie dedicated to transforming themselves. We value efforts where those who benefit have the chance to shape their own path to self-determinatior and we help them create their own opportunities where barriers often exist.

PROS (Personalized Recovery Oriented Services)

Personalized Recovery Oriented Services (PROS) is a complete recovery program that brings rehabilitation, support, and clinical services together into one plan that supports a person's goals and hopes. The person collaborates with the rehabilitation practitioner to develop their Individual Recovery Plan (IRP). In the IRP the person sets a goal (or goals) and selects the best services to help attain this goal. The person sets the pace at which they wish to do this. This program allows the person to be in charge of their own recovery.

In 2007, HALI is the 1st in the U.S. to open a Peer Run Mental Health Clinic. The mental health system recognizes that when individuals are involved in their own recovery; develop relationships with others who share the same experience, chances for recovery greatly increases. Sinc 2007 participants decreased or eliminated dependency on public benefits, entered the job force or educational settings, and decreased crisis' and hospitalizations a significant saving to taxpayers.

Housing

Currently HALI provides Supported Housing to over 150 individuals in Nassau & Suffolk Counties. In addition to providing a rental subsidy, HAL case managers provide regular visits with the tenants to assist them in a multitude of activities from daily living skills, to employment and the acquisition of benefits. The housing is available through Single Point of Access (SPA) referrals for individuals with mental illness who are independent in maintaining their recovery activities

Advocacy

With the provision of both inpatient and outpatient advocacy, this program compliments traditional mental health treatment programs for individuals with serious and persistent mental illness and it is intended to promote consumers' rights and access to mental health, health, socia services, residential and other support service programs. Peer Advocates provide support in obtaining entitlement benefits such as DSS, SSI, and Medicaid. Assistance in completing forms for any other services, i.e. housing applications, are also offered. Completing an Advanced Directive to specify your preferred treatment in the event of hospitalization is another service Advocates provide.

Peer Networking Center

A peer community helping individuals with mental health life experiences. Services include: Self-Help Groups, Advocacy, Relationship building skills, Community resources, Peer Specialist Certification, Computer access and basic computer skill training, showers for individuals in need. Assistance for individuals seeking employment, Assistance and support for individuals interested in school and other trainings. Services also include support for those employed.

LEAP

The L.E.A.P. Program helps individuals who are newly entering or reentering the Suffolk County Mental Health Service System. L.E.A.P. staff works to create a safety net and linkages to essential services. Staff assists with self-help skills, accessing and establishing supports, entitlements and services available through community resources.

HALI Resource Center

The HALI Resource Center provides computer access to HALI participants. Participants are able to access employment resources, on line and self-help groups, email, social media and leisure activities, online education and training and other community and web-based resources. Book DVD's and games are also available.

Self Help

HALI's Self-help, mutual support groups offer emotional support and practical help with an experience, challenge or concern that is common to all members. Currently HALI facilitates several Self Help groups in the community.

159 Brightside Avenue, Central Islip, New York 11722, P 631.234.1925, F 231.234.7258, www.hali88.org

Appendix Eight
QUIZ ON MENTAL ILLNESS

Quiz on Mental Illness

1. Mental illness is a single, rare disorder and doesn't affect the average person.
   True False
2. Most people who struggle with mental illness live on the streets or in mental hospitals.
   True False
3. A person can recover from mental illness through prayer and by working on positive thoughts and a positive outlook.
   True False
4. Medication is a useful treatment for most forms of mental illness.
   True False
5. People often won't talk about mental illness because it is viewed as a weakness or personality fault.
   True False
6. People with mental illness are poor and/or less intelligent.
   True False
7. People with mental illness are not likely to be violent and dangerous.
   True False
8. Christians experience mental illnesses at the same rate as non-Christians.
   True False
9. Only professionals can help someone who has a mental illness.
   True False
10. There is little we can do as churches to help support people with mental illness and their families.
    True False

Appendix Nine
SERVICE POEM

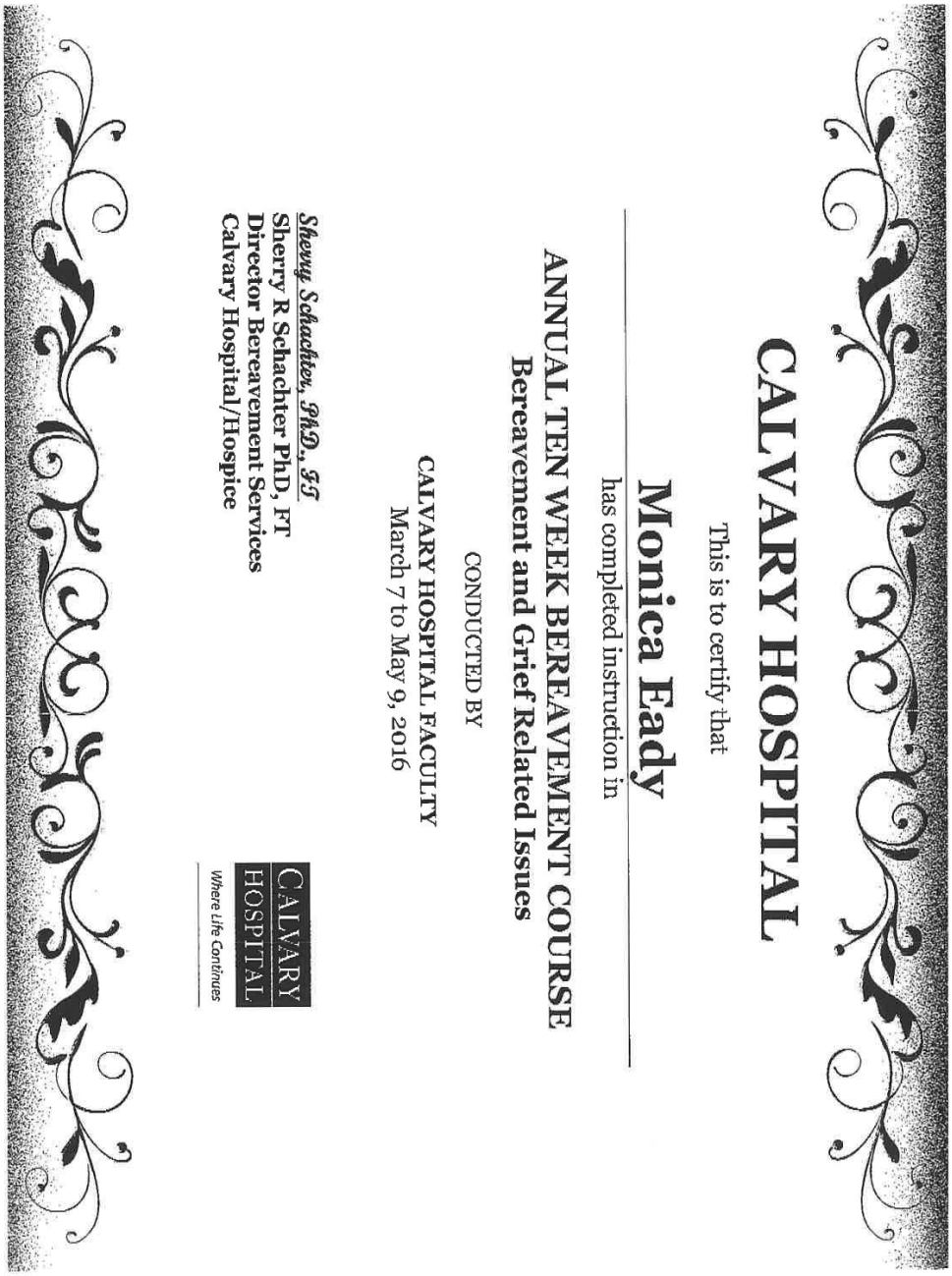
A Life That Matters - Unknown

Ready or not, some day it will all come to an end.
There will be no more sunrises, no minutes, hours, days.
All the things you collected, whether treasured or forgotten, will pass to someone else.
Your wealth, fame and temporal power will shrivel to irrelevance.
It will not matter what you owned or what you were owed.
Your grudges, resentments, frustrations, and jealousies will finally disappear.
So, too, your hopes, ambitions, plans, and to-do lists will expire.
The wins and losses that once seemed so important will fade away.
It won't matter where you came from, or on what side of the tracks you lived.
At the end, whether you were beautiful or brilliant, male or female, even your skin colour won't matter.

So what will matter? How will the value of your days be measured?
What will matter is not what you bought, but what you built; not what you got, but what you gave.
What will matter is not your success, but your significance.
What will matter is not what you learned, but what you taught.
What will matter is every act of integrity, compassion, courage or sacrifice that enriched,empowered or encouraged others.
What will matter is not your competence, but your character.
What will matter is not how many people you knew, but how many will feel a lasting loss when you're gone.
What will matter is not your memories, but the memories that live in those who loved you.
Living a life that matters doesn't happen by accident.
It's not a matter of circumstance but of choice.
Choose to live a life that matters.

Appendix Ten CERTIFICATE OF COMPLETION

FOR BEREAVEMENT COURSE



CALVARY HOSPITAL

This is to certify that

Monica Eady

has completed instruction in

ANNUAL TEN WEEK BEREAVEMENT COURSE
Bereavement and Grief Related Issues

CONDUCTED BY

CALVARY HOSPITAL FACULTY
March 7 to May 9, 2016

Sherry Schachter, PhD., FT
Sherry R Schachter PhD, FT
Director Bereavement Services
Calvary Hospital/Hospice

CALVARY HOSPITAL
Where Life Continues

Appendix Eleven
HALI CELEBRATION OF LIFE

Celebration of Life

February 18, 2016



They Loved, They laughed, They Lived

Bill.....Audrey.....Anthony

.....Remember

Order of Service

Musical Prelude

Processional

Prayer……..Min. Eady

Words……..H.A.L.I Family

Words of Welcome……. Executive Dir.

Life Tribute…….Patricia (Hali-Buddy)

Brief Informal Tribute……Breakfast crowd (H.A.L.I)

Flower Procession…….Family, Friends, Staff

Bell Tones & Announcement of Departed……..James

Thank-You's

Closing Prayer……..Min. Eady

Please Join us for a Repast immediately following Service

Appendix Twelve
COUNT ON ME

"Count on Me"

Performed by Whitney Houston & CeCe Winans
Written by Kenneth "Babyface" Edmonds, Whitney Houston & Michael Houston, Arista Records 1996



Count on me through thick and thin
A friendship that will never end
When you are weak
I will be strong
Helping you to carry on
Call on me, I will be there
Don't be afraid
Please believe me when I say
Count on...

I can see it's hurting you
I can feel your pain
It's hard to see the sunshine through the rain
I know sometimes it seems as if
It's never gonna end
But you'll get through it
Just don't give in 'cause you can

Count on me (mm) through thick and thin
A friendship that will never end (ah)
When you are weak
I will be strong
Helping you to carry on
Call on me, I will be there
Don't be afraid
Please believe me when I say
Count on...
You can count on me

Oh yes you can (ah)
Oo, I know sometimes it seems as if
We're standing all alone
But we'll get through it
Cuz love won't let us fall

Count on me (count on me, i'll be there) through thick and thin
A friendship that will never end
When you are weak

I will be strong (I'll be strong)
Helping you to carry on (yes, you know)
Call on me, I will be there
Don't be afraid
Please believe me when I say
Count on...
Count on...

There's a place inside all of us
Where our faith in love begins
You should reach to find the truth in love
The answers' there within, oh
I know that life can make you feel
It's much harder than it really is
But we'll get through it (we'll get through it)
(Just) Just (don't) don't give in (oh)

Count on me (count on me) through thick and thin
A friendship that will never end (it'll never end)
When you are weak (you)
I will be strong (I will be strong)
Helping you to carry on
Call on me, I will be there
Don't be afraid (don't be afraid now)
Please believe me when I say
Count on
Count on
Count on
Count on
Count on
Count on me
Oh yes you can
I know I can
Yes you can
Well
So glad I can, count on me

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